University of Alberta

Competency and the Provider-Patient Contract

By

Duncan Jeffrey McLaughlin ©

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

Department of Philosophy

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The Undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled *Competency and the Provider Patient Contract* by Duncan Jeffrey McLaughlin in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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For Mom and Dad.

Abstract

This dissertation promotes a liberal communitarian contract theory of medical ethics. It is motivated by the needs of patients and the community to have a greater participatory role in health care situations. It is also motivated by a desire to balance the interests and rights of all those who are directly or indirectly involved in the provider-patient relationship.

The author argues that many criticisms of the traditional contract theory approach to medical ethics can be dismissed, however, there is reason to be concerned over the issues of contractual individualism and minimalism. Robert Veatch's attempt to address these issues by offering a triple level social contract/covenant is found to be unsatisfactory due to its inability to adequately account for the role of incompetents in contract. Accordingly, a satisfactory theory must recognize the impact of incompetency upon the dynamics of the provider-patient relationship. In light of this, a refined version of Buchanan and Brock's account of competency is promoted.

Hugh Collin's interpretation of modern contract law suggests that contract law is (or should) be promoting fairness, trust and co-operation. His work provides the author with the template for the development of a liberal communitarian contract theory of medical ethics. This theory strives to balance the positions of the provider, the patient and the community. The

community is to determine the parameters of the provider-patient relationship since it is impacted by the decisions that are made by the providers and patients. By invoking a guarded use of beneficence and a limited sense of autonomy and by promoting care when cure is impossible, we thereby reduce the concerns over individualism and minimalism.

An extensive variety of inter-related issues are featured in this dissertation including: incompetency: surrogate decision-making; advance directives; objective and subjective interests of patients; community interests; the decision-making dynamics of health care providers and patients; informed consent; the restriction or limiting of futile or unproven treatments; cost-containment; and the inclusion of nurses in the health care team. All of these issues are discussed within the setting of Canada's universal health insurance program.

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Jeff McLaughlin, Kamloops, BC
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Illness is the night-side of life, a more onerous citizenship. Everyone who is born holds dual citizenship, in the kingdom of the well and the kingdom of the sick

- Susan Sontag, **Illness as a Metaphor**[1]

CHAPTER ONE

An Overview of the Dissertation.

I. Introduction

One of the seemingly progressive results of modern medicine is that the envelope of human life--its beginning and end, has been pushed back: human beings are surviving earlier and longer than ever before. With these advances there comes a price: emotionally, socially, financially, and ethically. For when we start hearing less about the right to life and more about the right to die we have to ask if medicine has gone too far and gotten lost in the glory of its own successes. Medical decisions and more significantly, the relationships between health care providers and their patients, have taken on a new importance. Accordingly, this work tries to establish, if not re-affirm, the rights, the responsibilities, and the roles of those providers and patients.

This work is primarily concerned with examining and promoting a liberal communitarian contract theory of medical ethics so as to bring patients back into the medical equation -- an equation that they are, for one reason or another, often left out of. Secondly, it is concerned with addressing the possible interests and rights of those we would call incompetent as well as the interests and rights of those who provide for them. Thirdly, it is concerned with the decision-making dynamics of the provider-patient relationship within the confines of the sociological, political and economic parameters that make up the Canadian health care system.

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[1] Sontag, S. **Illness as a Metaphor** (New York: Anchor Books, 1987) p.3.

Although the title of this work suggests a general and comprehensive treatment regarding health care providers, space dictates that the focus within these pages is necessarily centered upon the physician-patient relationship. It is hoped that by developing this particular medical ethic we will be then able to broaden the scope of the proposed thesis to include other health care providers in a team-oriented/multi-party contract. Accordingly, if successful, this work will not only give reason to promote a contractual relationship between physicians and patients but it will also provide ethicists, medical personnel and lay persons with a template by which they can overcome potential inter-professional conflict in their specialized dealings with individuals who enter the medical system.

II. The Thesis Structure

There are many aspects to the view that the provider-patient relationship, and the ethical judgments which stem from this relationship, ought to best be interpreted as a quasi-legalistic liberal communitarian contract relationship. What follows is a brief outline of the proposed argument.

We need to start our examination at the basis of the problem. Many objections are raised against the Hippocratic Oath, which is adopted by the medical profession. One such objection focuses upon the fact that some of the content of the Oath is irrelevant in the technological world of modern medicine; another objection notes that members of the medical profession are somewhat selective as to which parts of the Oath to abide by and which parts to ignore. These concerns are in addition to the central criticism that focuses upon the moral legitimacy of the Oath. The main reason for our rejection of the Hippocratic Oath is that the Oath directly and indirectly affects those (i.e., patients and the community) who were not party to its formulation. Accordingly, regardless of the Oath's contents (and the merits of said contents) the medical profession's imposition of what seemingly amounts to no more than a pledge to each other is ethically unacceptable.

There are many ways to try and address this unacceptable state of affairs. Indeed, many unsatisfactory models of the physician-patient relationship have been developed over the years. Some of these models remain extremely paternalistic (e.g. the "physician as warrior" model) while others are unrealistic (e.g. the "physician as colleague" model). A more promising response to the concern regarding the moral legitimacy of the Hippocratic Oath is the development of a contract theory of medical ethics which would entail that those who are affected by the Oath consent to its content.

As appealing as the contract approach may seem, some have raised objections against a traditional contract approach as being essentially unsuited to the physician-patient relationship in that it fails to accurately describe the interactions between physicians and patients. Others have argued that the adoption of a contract theory of medical ethics would result in performing a regrettable disservice to both parties.

Roger Masters rejects the contract interpretation on the grounds that he sees areas of dissimilarity between standard legal (market driven) contract relations and the physician-patient relationship. These areas of contention include that patients cannot be said to consent to buying the product, that physicians have virtual monopolies, and that third-party payers are increasingly involved in medical decisions.[2] These three points, claims Masters, highlight the differences between what individuals contract for in the marketplace, and what individuals consent to in the doctor's office.

William May charges that the move towards the adoption of a contract theory of medical ethics would be unfortunate since contracts are minimalist in nature.[3] The minimalism of a legalist contractual theory would have physicians "merely" fulfilling their contractual obligations. The concern is that this minimalism would create a physician who would be unwilling to go to beyond the call of duty for their patient. May, in claiming that legal contracts will produce "a professional too grudging, too calculating, too lacking in spontaneity, too quickly exhausted to go the second mile with his patients along the road of their distress"[4], seems to be placing a great deal of weight upon the caring nature of the physician. Yet given what is expected of the modern physician some degree of minimalism may be unavoidable.

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[2] Masters, R. "Is Contract an Adequate Basis for Medical Ethics?" *Hastings Center Report* 5 (December 1975) pp. 24-28.

[3] May, William F. "Code, Covenant, Contract, or Philanthropy" *Hastings Center Report* 5 (December 1975) p. 34.

Nevertheless, given that *laissez-fáire* contracts are minimally constrained it would appear that an extremely individualistic approach to medical decision making (i.e., where the decisions are made by the individuals and are not constrained by social institutions) would warrant the condoning of the performance of actions that would commonly be perceived as immoral (e.g., the physician who honours the request of a patient to remove a healthy limb). Furthermore, given that legal minimalism needs to be addressed, attempts have been made to move away from a legal contract theory of medical ethics to a social contract approach. Robert Veatch, in his attempt to find a morally legitimate grounding of a medical ethic, develops a tripartite social contract that starts with the displacement of the Hippocratic Oath.[5]

Veatch's solution looks beyond mere consequences and enters into the realm of a multi-principled ethic. Briefly, the first level of the triple-level contract contains the over-arching moral principles originally agreed to by individuals in an original position. These principles, which include promise-keeping, autonomy, truth-telling, avoidance of killing, and the just distribution of benefits and burdens, will govern over all relevant interactions. The second level specifically concerns the establishment of a contract between the medical profession and society. In the third and final level, additional duties and rights between the individual physician and patient are established within the confines and limitations set out by the first two levels.

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[4] May, William F. "Code, Covenant, Contract or Philanthropy" *Hastings Center Report* 5 (December 1975) p. 35.

[5] Veatch, Robert M. **A Theory of Medical Ethics** (New York: Basic Books, 1981).

Veatch's attempt is admirable and yet it falls prey to many criticisms. First, Veatch faces the problem of the possibility of conflicts within a multi-principled theory. Secondly, there is the problem that faces traditional social contract theories which concerns the relevancy of a momentous yet hypothetical event upon the real. More crucial, however, is Veatch's attempt to blur the two distinct notions of contract and covenant as a response to minimalist concerns. Yet, in the analysis of "covenant", we find that Veatch's suggestion that his notion of contract is akin to a marriage contract in which fidelity and trust are emphasized comes very close to being a promotion of an unacceptable imbalance of power between physician and patient.

Along a similar train of thought, one line of reasoning suggests that even if *some* physician-patient relationships can be adequately interpreted as being contractual, there are some situations where it appears that both parties cannot be mutually engaged in contracting with each other. The most obvious of these is when the unconscious patient is brought into the emergency room. Surely, goes the argument, it cannot be said that the unconscious patient gave his/her "consent" to the treatment.

A final concern regarding the application of contract to medicine is that the notions of contract and incompetence appear to be incompatible. It is peculiar at best to suggest that incompetents can enter into contractual relationships. An analysis of incompetency will reveal that different types of incompetency pose different problems for a contract theory. If we are dealing with a person who was once competent but no longer is, it may be best to carry out the previously established contract with the individual (assuming that there was one). However, if the incompetent is a newborn or a severely handicapped minor then they have never been in the position to enter freely into a contract relationship and thus tension still exists.

Still, granted that physicians and incompetent patients do have some sort of relationship, we are faced with a quandary. Do we outright dismiss the usefulness of a contract theory or do we opt for one which holds that the contract exists between the physician and some third party on the behalf of the patient--thereby reducing the role of the incompetent to that of a bystander in much the same way that the role of the patient is now reduced under the Hippocratic Oath? Neither option is palatable; however, the second option, which looks at decisions made on the behalf of patients, will be addressed by focusing upon the issue of futile treatment, surrogate decision-making and the role of the community. In any event, the sorts of criticisms leveled against Veatch's proposed solution can be avoided or deflected by a move towards a more legalist approach.

It is argued that a liberal communitarian contract theory of medical ethics can successfully avoid the concerns of Masters and May and still remain within a legal framework. By remaining within a legal framework we can avoid the awkward difficulties associated with Veatch's social contract position. Moreover, this thesis serves to provide a promising interpretation of the physician-patient relationship as it offers a reasonable way to resolve the more pressing problems hinted at above while at the same time ensuring personal autonomy, fairness, trust and an adherence to a socialized system of health care.

The liberal communitarian interpretation offered here is inspired by the work of Hugh Collins.[6] It suggests that Masters' concerns over contract are misplaced due to the perceived movement away from a traditional *laissez-faire* approach in contract. Indeed, if it is true that contracts are no longer one-to-one transactions and if the law of contract is moving towards a community-minded and community-guided approach, then we can remove the need for separate decision-making rules and standards for competents and incompetents. This is done by placing community guided restraints on the various choices of medical treatment that patients are allowed to make--restraints that are to be justified by the liberal communitarian desire to promote human flourishing.

Ultimately, the theory that is proposed is based upon the interpretive insights of modern contract theory, liberal notions of regard and respect for self-determination, and communal sensibilities which will define the parameters of the physician-patient relationship. It is maintained that this conciliatory regard, which may be called "liberal communitarianism", is in keeping with a society that places great value upon a universal health care system. This universal system itself offers evidence for the high value that society puts on the well-being of its citizens and the fairness of distribution. Because we are not a society of one and because there are conflicts of interests and scarce resources, we must balance toleration of those whose subjective values and objective interests are different than ours with the interests of all concerned. Thus, a line of what is, and is not acceptable or most efficient must be drawn to prevent abuses of the health care system as well as the abuses of knowledge, power and the authority of health care providers.

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[6] Specifically, Hugh Collins' **The Law of Contract** (London: Weidenfeld and Nicolson Ltd., 1986).

The justification for the liberal communitarian interpretation by which community standards define the parameters of the physician-patient relationship and the justification for the rejection of the professional-centered tradition is this: if we as persons, citizens and members of a diverse community are not allowed to participate in the processes that affect us directly or indirectly then we will be left as bystanders on the sidelines of our own lives. Such a state of affairs is unacceptable since to be left on the sidelines is to give control over how our subjective desires and objective needs are perceived, managed and manipulated by others. The importance of retaining personal control over one's interests, when coupled with the nature of socialized medicine, illuminates the social and moral practices within Canada. Namely, an individual's well-being and freedom should be viewed in the context of the interests of the society and vice versa. Liberal communitarianism does not needlessly sacrifice the interests of one individual in favour of another individual or a collective.

III. The Socio-political framework.

A few preliminary comments need to be made to clarify the socio-political context in which the dissertation thesis is presented. The contract theory developed herein is intended not to work within a vacuum but to be immediately applicable to one particular society: Canada. If, as I hope, this theory is suitably applicable to other societies which currently maintain similar but different sorts of health care systems then so much the better for the thesis. Accordingly, I am not overly concerned with possible rejoinders that the ethical foundations, upon which my interpretation of the physician-patient relationship is based, are not universal or objective truths.[7]

---

[7] Some people jump from the sociological evidence that different societies appear to react differently in various situations to the conclusion that ethical relativism is true. If a cultural relativist were to point out that different people act differently in different situations, this claim would not be very profound since there is no common circumstance in order to judge the rightness or wrongness of the particular person's action. But there is a more interesting claim to be made by the relativists, this being that the different moral actions taken by different people or societies or cultures gives evidence that there is no true moral standard, or instead, that these differences point to the conclusion that there are many morally acceptable standards. With this latter claim, two concerns are apt to be blurred. A relativist might argue that when we look at how two different cultures react in a similar situation the actions taken by these cultures suggests that culture A says 'help others' while culture B maintains 'harm others'. The conclusion that the naive relativist draws from this is that there is no moral truth in the absolutist sense. But a second approach is to say that in a given situation the different actions of A and B are not the result of differing standards but of different interpretations that A and B place upon the moral statements 'help others' and 'harm others'. In other words, the different behaviour of A and B may be attributed to what actions they believe satisfy the standard. One cannot deduce from descriptive

Regarding the matter of universal truths, it is noted that although what we want or need as autonomous agents may vary from person to person, there are some things that are common to all. Thus, these needs might constitute some "universal truths" that are perhaps a little less abstract than those which are alluded to in the previous paragraph. On a deeper level, the promotion of universal health and wellness and the desire to prevent undue suffering and death is to make a value judgment about these states of affairs. In other words, it is not only in the interest of persons that they be well, it is also desirable and desired by society. While our physical, psychological, emotional and intellectual differences separate us from our fellow human beings, we all share in common the fact that we are born naked and helpless into the world. An appreciation of this fact and its symbolism serves to ground us to the commonly held view of Canadians that some degree of health care access is a right of all citizens. Accordingly, this lends support to the view that there are some elements of communitarianism in our country.

That there are such health care rights in Canada means that an individual has the right to various medical treatments and that others may have a duty to provide medical assistance. The importance placed upon the value of a person's being able to seek freely necessary medical care and his/her also possessing the right to refuse such care if he/she so wish

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relativism that epistemic relativism is correct. That is, one cannot deduce that from the behaviour of individuals in different cultures that different cultures make different moral evaluations regarding certain actions nor that there are different moral standards. Given the particular circumstances of various cultures different moral evaluations may result from the same universal standard.

stems from the societal interest of autonomy as well as the toleration of subjective or personal interests.

The realization that other members of our community have an interest in their own welfare provides us with reason to reject relativism. Some notion of universal concern for the well being of (at least some of) the members of the community is required for the continued existence of that community. The tendency towards prohibitions against homicide, the protection of the young, the rejection of needless violence and so forth may be considered if not moral rules, socially pragmatic guidelines which are held in common by all communities in order to preserve and promote their flourishing.[8]

Whether we adopt the universalist or relativist approach, I believe that it is safe to say that a principle of toleration is an important tenet within the ethical codes of liberal democracies. It is a value that is constantly tested and reaffirmed to such an extent in our pluralistic society that some have suggested that the standard of tolerance is an essential element reflected in "who we are" and "who we aspire to be" as a nation.[9] As such, within our Canadian setting, whether one argues for the relativist position or the universalist position, so long as the position tips its hat towards some level of toleration, then many will find either approach to be agreeable. The abstract grounding of this toleration would seem to arise through two principled means. The first being the fundamental importance that Canadians place upon the principle of autonomy: that one has a limited right to act according to one's own determinations. The second is the principle and sentiment of benevolence, which makes us prefer and approve of certain actions over others. For, if we are concerned about the joys and sorrows of others and if reason can show us which acts are most efficient to attain these interests (the "joys") or avoid those harms (the "sorrows"), then being reasonable persons we will act accordingly and perform those acts which benefit others and ourselves.[10] Furthermore, if we cherish our own abilities and capacities to do as we choose, then, so long as it does not cause any unnecessary or undeserved harm in others, we would most likely consent to an agreement which justifies our being left alone. A rational collective would, I suggest, agree that such a right could be given to an individual who in turn recognizes that same right for others.

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[8] For more on this point, see Rachels, J. **The Elements of Moral Philosophy** (New York: McGraw-Hill, 1993) Chap. 2.

[9] Taken from the preamble to the proposed "Canada Clause" which was to be entrenched in Section 2 of *The Constitution Act, 1867*. Government of Canada Constitutional Proposals, 1991.

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[10] Hume, David **Enquiry Concerning the Principles of Morals** (London, 1751).

Scandalized voices murmur that...operations are necessary. They may be. It may also be necessary to hang a man or pull down a house. But we take good care not to make the hangman and the housebreaker the judges of that. If we did, no man's neck would be safe and no man's house stable.

-George Bernard Shaw, **The Doctor's Dilemma**[1]

CHAPTER TWO

The Rejection of the Hippocratic Tradition

I. Introduction.

A tradition can have awesome power over those who work from within it. As such, it is often quite difficult to distance one's self from what one has uncritically accepted as being just "common practice" in order to objectively evaluate the tenets or the principles that lie behind the tradition. Accordingly, revising or rejecting traditions is made complicated by the uphill struggle to win over members of the old guard who feed the fires of the tradition by their continued practices. Such persons keep the tradition alive and keep the pressure on those who wish to challenge the entrenched views. Traditions, then, are difficult to ignore and even harder to overthrow.

Challenging traditions, whether they be ritualistic spiritual traditions or professional traditions, is also made difficult because of the various standpoints that one can take. However, just as allegiance to the Hippocratic Oath once established a tradition, we must note that it is clearly not the case that "things have always been done in a certain way or in agreement with certain principles" because at some point in human history traditions have to get started. By rejecting the old ideas, new ideas are able to spring forth and provide the basis for new traditions. It is a fallacy to appeal to mere existence of a tradition as sole evidence of its being meritorious. Some traditions are good (like celebrating birthdays); some are bad (like child labor) yet both continue. Further, if we did not challenge traditions that people held there would not be any room for social reform: We would continue to view women as chattel and we would still crucify non-believers. The fact that people continue to follow a tradition is just one reason we may find a tradition worthy of continued support. More to the point, we need to investigate *why* people continue on with the tradition. What is it about the tradition that makes it attractive to so many?

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[1] Shaw, George Bernard. **The Doctor's Dilemma** (London: Constable, 1911).

It is not difficult to understand why physicians might be attracted to the Hippocratic Oath tradition as it gives them great power and authority over the health and well-being of others. It is also not difficult to understand why they can be defensive about the Hippocratic Oath tradition. From the inside looking out, one can be biased in favor of the tradition; appealing to the tradition simply on the grounds that it seems to be useful and that it is somehow essential to the profession. From the outside looking in, one can fail to appreciate the nuances and characteristics that are vague or troubling to those who have not directly experienced the workings of the tradition. These barriers are difficult to overcome and yet that is our goal: to challenge the ancient Hippocratic Oath tradition by pointing to its flaws. It is then our duty to be critically reflective while maintaining our objectivity regarding any possible merits of the Oath that have influenced the physician's conduct and treatment of patients for two thousand years.

II. The Rejection of the Hippocratic Oath.

Not to challenge the merit of the stated guidelines of the Oath and the beliefs of its followers is to neglect the philosophic necessity of the marketplace of ideas.[2] One cannot just *assume* that a proposal is worthy even if it is worthy. Rather, one must analyze it and then make the appropriate determination -- a determination that may just reaffirm that it is in fact the best approach! Unfortunately, this will not be the case with the Hippocratic Oath.

The Hippocratic Oath as an ethical guideline is unacceptable for a variety of equally significant and inter-related reasons. These reasons include: its limited range and applicability due to its moral illegitimacy over patients; its inappropriate content which creates professional conflicts as well as being at odds with modern values and technologies. Furthermore, one must question why there is a piecemeal application of the Oath by the very same professionals who swear to abide by it.

---

[2] This idea is clearly an application of John Stuart Mill's views. Mill, in speaking out about freedom of expression forcefully reminds us that even if a belief is ultimately found acceptable, the challenge of other opinions forces those who maintain the belief to defend their position and enables these persons to have better grounds for rationally accepting the belief rather than relying on grounds of blind faith or dogmatic rigor. See John Stuart Mill, **On Liberty** Chap 2: "Of the Liberty of Thought and Discussion" (1859).

Here is the Oath:

> I swear by Apollo Physician and Asclepius and Hygieia and Panaceia and all the gods and goddesses, making them my witnesses, that I will fulfill according to my ability and judgment this oath and this covenant:
>
> To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art -- if they desire to learn it -- without fee and covenant; to give a share of precepts and oral instruction and all the other share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but to no one else.
>
> I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.
>
> I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art.
>
> I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work.
>
> Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.
>
> What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread aboard, I will keep to myself holding such things shameful to be spoken about.
>
> If I fulfill this oath and do not violate it, may it be granted to me to enjoy life and art, being honored with fame among all men for all

> time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.[3]

III. A Faulty Process

A medical ethic is needed to oversee the physician-physician relation as well as the physician-patient relation. However, there is a general problem stemming from a tradition of having the profession determining the sorts of rights and duties that are appropriate within this ethic. Patients are affected by these pronouncements and yet they retain little or no input into what sorts of ethical rights and obligations that they or the professionals ought to bear.

Some physicians may attempt to ground their ethical obligations to the profession and to their patients by means of a pledge and by group solidarity and loyalty. This is unacceptable since it assumes that physicians are a privileged group who has some special duty over others to promote the welfare of others. Although a defense of this assumption might be given, the obligations cannot be established by the mutual agreement of the professionals without some sort of external justification of the principles and the method by which they are adopted. That a profession believes or decides that confidence should be kept does not provide adequate reason for resolving the question of whether keeping confidences is ethically right. More controversial than this assumption of having the power and authority to promote patient welfare is the assumption that physicians (whom we acknowledge as possessing expertise in medicine) will also have the knowledge and authority to determine the ethical parameters of the physician-patient relationship. That one is competent in medicine does not necessarily entail that one is competent in the ethical application of one's skill and training. Although Nazi doctors were skilled in applying their medical knowledge to their research, few would maintain that this research is untainted by the gross immorality of their actions upon human subjects.

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[3] "The Hippocratic Oath" in Ludwig Edelstein, **Ancient Medicine**, ed. Oswei Temkin and C. Lillian Temkin (Baltimore: Johns Hopkins University Press, 1967).

After a review of the first few paragraphs of the Oath, the Oath is seen as a pledge to the Gods to respect and adhere to certain values and beliefs that uphold the profession. The question arises as to how the Oath can be considered binding upon non-physicians who are the subjects of many of the Oath's directives. The answer is that it cannot because the Oath cannot be used as justification for its own adoption. To do so is to be self-referential and begs the question of the Oath's legitimacy. Such a move might allow for the establishment of mutually agreed upon guidelines for physician-physician relations but it cannot justify the profession's having certain rights and duties over patients since these "non-physicians" were not recognized as being party to the pledge or in its continued maintenance. Moreover, a medical ethic that rests on universal foundations that can be only be determined or known by professional consensus provides little reason (or comfort) for non-members to put their faith in the profession's claim that these foundations have been interpreted correctly.

There is nothing inherently wrong with two competent individuals freely agreeing to act in a certain way with each other. However, it would be improper for these two individuals (e.g., two physicians or the profession as a whole) to decide what sorts of relations they are going to have with a third party (e.g., the patient). To do so is to assume responsibility over that third party and take control away from that third party. Of course, if the third party agrees to this state of affairs, then we would have a different situation since it would recognize and incorporate the importance of the third party's rights and responsibilities. But then this would be an agreement reached between the two original parties *and* the third party. This particular state of affairs does not capture the workings of the Hippocratic Oath.

As further evidence for the conclusion that the Oath has excluded the patient from his/her rightful participation in the agreement we see that according to the Oath the physician pledges not to favour or side with the patient on various matters regardless of his/her wants and possible interests:

> I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect...In purity and holiness I will guard my life and my art.[4]

Imagine the unease a community would have if corporations were allowed to set the ethical parameters of their dealings with other corporations. Now also imagine that these rules extend beyond their internal business dealings to include the customer. These rules dictate to the customer what services they can or cannot have. Furthermore, these guidelines make it difficult for other competing businesses to enter or threaten this order. Then consider that the corporations justify the guidelines on the grounds that *they* believe the guidelines are most appropriate regardless of the views or opinions of the customers. I surmise that the consuming public would be concerned about the potential for conflict of interests and would also suspect collusion. Further, any sense of marketplace stability that the public might rely upon is undermined by the corporations' ability to ignore or change these guidelines as they see fit. This is a monopoly that does not allow those who receive services and who pay the fees to have a say in matters which affect them directly. Clearly, this state of affairs is one that would not be accepted easily by the consumer. Nevertheless, this picture is not a far cry from what we have with the Hippocratic Oath.

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[4] "The Hippocratic Oath" in Ludwig Edelstein, **Ancient Medicine**.

Although we are not in any way suggesting that the medical profession is somehow "evil", there is the perception of its being self-serving. The self-regulatory nature of the Oath warrants the strong view that the traditional approach is morally illegitimate regardless of the merits of the stated guidelines once these guidelines no longer solely focus upon physician-physician relations.[5] What we want instead is a legitimate professional ethic-- one that has the profession's code of ethics and its subsequent authority to adjudicate in ethical disputes accepted by the community.

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[5] This is not to say the general public is, or would be happy about any sort of 'in-house agreement' that is reached by various professions even though the agreements may not have any real impact on the public at large.

IV. A Question of Content.

Let us turn to our second criticism regarding the Oath. The content of the Oath is inappropriate and its implicit values are often at odds with the modern world. This, in turn, is a reason why even those who may have once stressed their steadfast adherence to it now challenge the Oath. Accordingly, it will be argued that if these challenges have merit, then there are other factors guiding the ethical behavior of the physician.

The Oath not only provides guidelines to the physician regarding medical matters, but also demands a strict discipline over every facet of his/her life. This intrusion into the physician's affairs may be considered overwhelming, especially to that generation of medical students who treat their work more as a means to obtain financial amelioration than as a "way of life". It might be a minor consideration to point out that physicians probably don't consider their instructors as equal to their parents -- as it is perhaps asking too much of the medical student whose parents paid his/her way through college. As well, physicians probably don't lend money to their colleagues any more or less than any another profession. The profession now recognizes that women can become capable physicians just as their male counterparts, which goes against passing the medical tradition from son to son. Additionally, "the houses that they visit" typically are not the houses of their patients but rather are places that *house* the ill, namely, public and private hospitals and institutions. Each one of these minor discrepancies points to a particular professional activity that has evolved away from the letter of the Oath.

"Things change" might be the retort given to the recognition of the shifting professional behaviour that has occurred over time. Indeed, it is quite true that things do change, greater wisdom is amassed, new attitudes and beliefs are established and new technologies are developed which dramatically alter professional and public expectations. This is the whole point of our criticism: among other things, a changing world will put pressure on the acceptability (or efficiency) of past practices and may require the evolution or revolution of an earlier belief or position. As this belief evolves, so too does our perspective on the world. It is necessary that rules of conduct are created or re-interpreted to account for new social realities. These rules form part of the challenge against the old ways and are sometimes enshrined within the legal system as it tries to react to the social realities (e.g., bubble laws to prevent protesters from harassing abortion clinic clients, or obscenity laws to govern over the transmission of pornographic materials over the Internet, etc.)

The ancient physicians did not have to worry about life support systems or organ transplants or antibiotics so it is understandable why they didn't offer specific guidance in these areas. However, they did have the ability to perform crude abortions, yet these were ruled as impermissible. Modern physicians remain explicitly prohibited from performing abortions, yet many continue to perform them and are trained to do so in medical school. Accordingly, this suggests that the permissibility of abortion has been institutionalized in some communities at least. Indeed, so strong is the belief that performing this procedure is an essential service, that if the spectre of legislation against abortion is raised, some physicians take umbrage and argue that the decision is purely a private one to be made by the patient in consultation with his/her physician. If physicians, or more importantly, if the profession in general held fast to the Oath, this commonly heard defense of abortion would not be a viable option.[6] Ultimately then, the criticism is not only that the Oath cannot account for new advances, but that current and past medical practices are not in keeping with its guidelines.

Given the advances of modern technology which can extend the lives of those who previously would not have lived and which can cure ills and mend injuries that used to be fatal, the Oath is not only chock-full of inappropriate content, but it also promotes conflict between the important principles of autonomy and beneficence and between beneficence and non-nonmaleficence. This issue (which is addressed in the next section) is not surprising given our first criticisms.

V. An Issue of Paternalism.

The Oath states that the physician is to act according to his/her ability and judgment as to what will benefit the patient. What the Oath does not tell the physician is that he/she is to do what will benefit the patient *unless the patient refuses.* This is medical paternalism since it allows for the interference of a person's freedom on the grounds that it is for the good of the person. This statement promotes the creation of rights for the physician while ignoring the need for patient consent. We obviously accept that physicians in general possess more medical knowledge about the physical well-being of their patients than do the patients themselves and this is the reason why we seek counsel with them. However, whether this fact justifies physician control over the patient remains highly questionable. Even more serious is when physicians extend their medical expertise into areas that might appear, at first glance, to be matters of medical knowledge but are actually complex (and often very personal) matters of moral decision-making. Accordingly, we have medical experts making moral pronouncements about what, in their opinion, is in the best interests of patients.

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[6] The same insight might be carried over regarding the issue of euthanasia that is explicitly disallowed by the Oath. However, we must acknowledge that providing palliative care, including medication that is aimed at easing suffering, but that also has the effect of hastening death, might come under the heading of "benefiting the patient". Accordingly, palliative care may be entirely consistent with the Oath. However, this does not address the matter of assisted suicide.

Another conflict that arises out of the issue of promoting beneficence is that while physicians are to protect the patient from harm, a patient who exercises his/her autonomy by refusing treatment might be considered to be doing something that constitutes a “harm” (e.g., stopping chemotherapy treatments). Permitting this harm to occur would be at odds with the physician's duty to benefit the patient. Accordingly, what counts as “benefit” and what counts as “harm” needs to be reviewed not only in terms of medical benefit and harm, but also in terms of benefiting and harming the interests of the patient from an ethical standpoint.

When asked to give an account of their ethical actions, physicians may refer to their obligation to follow a professional principle of “do no harm” which is interpreted by some as being equivalent to their having a duty to do that which they believe will benefit the patient, or of "simply doing good". But these two statements are not interchangeable as they represent two different principles. A principle of non-maleficence or "do no harm" can require a commitment of the physician to do something other than what a principle of beneficence dictates since a physician's not harming you is not the same as his/her helping you. A person who does nothing is a person who is not harming you whereas a person who assists you or leads you to safety is a person who is benefiting you. That an innocent bystander must rescue you from a burning building is not required by the "do no harm" principle, but it is required by the principle of beneficence. Accordingly, the former principle places lesser demands on the physician than the latter.

Within the medical context, either of these principles of beneficence or non-maleficence may be in conflict with a more general ethical principle of "simply do good". For instance, keeping certain patient information confidential may be of benefit to the patient (e.g., the patient who does not want his/her spouse to discover that he/she contracted a sexually transmitted disease) and it may also be in keeping with the physician's duty to "do no harm" to his/her patient. Nevertheless, a policy of confidentiality in this case may not be in keeping with a principle of "simply do good" if by "doing good" we mean that we evaluate our actions on some grander scheme that extends beyond the individual patient-physician relationship. This potential conflict between "one-to-one" states and "one-to-many" (where "many" represents the community) is a concern that will be raised again in a later chapter under the rubric of "individualism".

VI. An Issue of Loyalty.

That the Oath contains inappropriate content leads to our third concern that has already been partially addressed. Physicians defend their actions by falling back upon their obligations that stem from the Oath. That is, physicians use the supposed moral and medical authority of the Oath as justification for their actions and yet they sometimes turn away from the Oath when they find it unsuitable for their needs. To do this, we said, is to be inconsistent. If a physician swears by the Oath and then rejects the stated impermissibility of say, abortion, then we must wonder what it is about this particular aspect of the Oath that motivates his/her rejection of it and what is it about the other parts of the Oath that results in their being accepted. Either the physician is arbitrarily choosing to adopt some elements and reject others in a piecemeal fashion or there is some outside guiding principle that he/she is using to decide what is acceptable and what is not. Since arbitrary decisions are unacceptable, in order for any components of Oath to have any semblance of ethical legitimacy, their content must be grounded elsewhere. Accordingly, in the next chapter, we will need to look at possible candidates that motivate these discrepancies between what the Oath says and what physicians do.

VII. Gods Shuffling their Feet.

In this chapter, we have been arguing that patients have been affected by the decisions and the actions of the physicians who have determined not only what rights and duties physicians have with each other, but also what rights the patients themselves have within the context of the application of medicine. The intimate relation between the Oath and its religious overtones is clear and may well serve as fodder for the angry and sometimes bitter portrayal of physicians as being the "high priests" of their medical order. The parallel between the autocratic priest answering only to God and the physician answering only to his/her colleagues is one that has been perpetuated by the cries of those who are dependent upon a group that wields too much power. The physician swears to Apollo and to his/her fellow physicians to obey the tenets laid out (that is, if he/she decides to obey them). Perhaps this symbolic allegiance by the medical profession to the gods is misplaced and should be redirected towards those who benefit or suffer from the actions of its members. In the next chapter, we shall look at a few possible ways that the relationship between physicians and patients may be perceived.

Healers. Scientists. Professionals. Entrepreneurs. Politicians. These five nouns have all been used to describe doctors.
- Michael Moran & Bruce Wood, **States, Regulation and the Medical Profession**[1]

CHAPTER THREE

Old Models, New Models

I. Introduction.

Instituting the directives of the Hippocratic Oath has the consequence of affecting the well-being of patients as persons. Unfortunately, the Oath does not bind the physician to make promises to the patient but rather binds him/her to make promises towards other members of the profession. The professional authorization that comes with these promises does not have any caveats attached to it and the open-ended application of this authorization to do what is judged to be of benefit to the patient suggests that "doctors know best". Such a process can be open to intentional and unintentional abuse and creates an atmosphere of inequality between the physician and patient. Whether or not the physician does in fact know what is best for the patient is irrelevant for the competent person who finds this imbalance of power and the lack of respect that comes with it morally offensive. Thus, it shall be more reassuring to look to sources other than the Hippocratic tradition for grounding the ethical foundation of the physician-patient relationship.

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[1] Moran, M. and Wood, B., **States, Regulation and the Medical Profession** (Buckingham, Philadephia: Open University Press, 1993).

II. Prescriptions of Ethical Conduct.

Robert Veatch in both **A Theory of Medical Ethics** and in the later **The Patient-Physician Relation**[2] claims that there are at least four models of the patient-physician relationship. Each of these proposed ethical models is an attempt to capture the best interpretation of the physician-patient relationship. While they may in fact reflect or describe what is common practice by individual physicians who adopt particular attitudes or approaches towards their patients (most notably that of the priestly model) these models are suggested as potential ethical alternatives which are subject to our evaluation. Veatch develops and then rejects three models in favour of the contract model of medical ethics.[3] Let us look at these discarded models, which includes the engineering model, the collegial model and the priestly model.

The engineering model is one whereby the physician's role is that of the applied scientist: his/her actions are directed by the patient's request and not by any consideration of the value of the act or request:

> ...(m)ake the physician an engineer who will turn over to the patient the task of picking the values and setting the objectives of the medical relation. This physician becomes a plumber making repairs, connecting tubes and flushing out clogged systems with no questions asked. In this model of the (physician-patient) relation, the patient is simply presented with the facts and allowed to decide whether to use medical science to fix what he or she perceives to be a problem.[4]

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[2] Veatch, Robert M. **The Patient-Physician Relation: The Patient as Partner** (Bloomington: Indiana University Press, 1991).

[3] Veatch, pp. 11-16.

[4] Veatch, p. 12.

Under this model, the physician has the medical expertise and will provide his/her skills at the request of the patient without making any value judgments regarding the merits of that request. Then, if the healthy patient requests a medically unnecessary procedure, the physician will provide it if he/she is so inclined. Clearly, this sort of extreme freedom which allows patients to buy the services of a physician much like the buying of a "hired gun" or a "hired hand", presents us with a situation where patients and physicians can potentially engage in behaviours that would be considered immoral (if not illegal) in the eyes of the community. As long as both parties enter the situation voluntarily, this model removes all social and moral constraints freeing the individuals to act as they so choose. The state and its interests (including the interest of the well-being of its citizens) are kept out of the doctor's office.

Hidden behind Veatch's use of the "engineering" name is the belief that science and its application are value neutral. Yet, to characterize the engineering profession in this manner is unfair and inappropriate. Engineers do have ethical codes, unlike what is implied by this model. Engineers do not offer their services to their clients with a blind eye towards safety issues; they have professional standards that must be satisfied otherwise the engineer would face incompetency and misconduct charges. Accordingly, an "engineering" model is one that is not value neutral. Instead, we must find a more accurate name to assign to Veatch's patient-driven model where, it would seem that if the patient has the money (or the determination), he/she can find whatever he/she wants. Something along the lines of a "consumer-centered model" or a "market model of health care" or an "entrepreneurial model" where the consumer is always right would be a more appropriate description. Whatever we call it, (let's settle on the "consumer model") it brings out a concern over extreme individualism whereby the physician is singularly focused upon his/her patient regardless of the value of the activity. That is, if the patient can afford it and if the physician is willing and able to provide the medical service, then there is no further ethical issue to resolve. However, where there are no social constraint upon the exercising of one's liberty, there is the problem of the consumer model providing too much power to the patient. Too much attention is given to the notion of autonomy while not enough attention is given to the social parameters that govern some inter-personal relations. If the patient indeed paid out of his/her own pocket for the medical services, then a case might be made for the freedom to contract. However, even if this were so, the individuals involved cannot contract to commit illegal acts. Furthermore, given that public purse strings play a substantial role in the delivery of medical services to members of the community, the public deserves to be able to hold the users and providers of the services accountable to some standard -- no matter how open or restrictive that standard might be. We note that regulation, which is a method by which we achieve accountability, has "proved perhaps the single most contentious issue in the whole area"[5] of medical care in the United States of America.

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[5] Moran, M. and Wood, B. **States, Regulation and the Medical Profession**, p. 80.

Veatch's engineering model, or what we are calling the consumer model, is one attempt to gain significant ground against the Oath's paternalism as it places self-determination (of both parties in this instance) as its highest principle. However, the consumer model is to be rejected as being too extreme a position. While maintaining respect for patient autonomy, it flagrantly rejects any over-arching standards that might exist -- including professional, social or legal standards. Furthermore, in tipping the balance of power completely over to the patient, it is disrespectful to the physician whose role is reduced to that of a mere tool.

Continuing with the "patient-driven" relationships, we might wish to consider adopting the collegial model. Here, the patient and the physician "should see themselves as colleagues pursuing the common goal of eliminating illness and preserving the patient's health."[6] This approach is commendable in that it implies a positive relationship between the two individuals. Indeed, the notion of collegiality has many affirmative connotations attached with it. If, as colleagues, the two individuals are similar to each other in matters such as outlook, then the patient will have a greater chance of having his/her needs met. If there is collegial sincerity, then there is opportunity for greater understanding, communication, trust and teamwork. All of these elements promote the patient's ability to pursue his/her own interests. However, Veatch rejects the collegial model on the grounds that it is simply a "pipe dream" due to the existence of "ethnic, class, economic and value differences"[7] between the two parties. In other words, it is unrealistic to believe that physicians and patients will see "eye to eye" given their different life experiences and situations.[8] To Veatch's "reality check" we can add further concerns and twists.

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[6] Veatch, p. 13.
[7] Veatch, p. 13.

When we are dealing with our friends and colleagues there is the assumption that we share some common bonds. These can be common interests and goals, as well as a roughly comparable set of abilities and talents. Friendships, and the like, are in part defined by the pursuit of mutual continued interaction by the parties involved. We seek the company of our friends because of the instrumental or intrinsic pleasure that is associated with the exchange of conversation, ideas and mutual support. However, when we have the need for a physician, we seek out someone who occupies a certain role. While it is perhaps true that we also seek out a particular physician for personal reasons such as his/her friendly nature, openness or bedside manner--elements which are undeniably important in promoting a healthy relationship; there is usually a knowledge gap between the physician and the patient. It is this knowledge gap that motivates the patient to seek medical attention. We appeal to the physician's authority to provide guidance on medical matters. It would seem then, that patients seek out physicians *because* of the imbalance of skills and knowledge not because they are looking for collegial relationships. Patients may then wish to continue on with the relationship because of a sense of shared respect and equality but these latter elements cannot be recognized or realized until after the initial meeting. It is this initial encounter which is driven by medical want and not a desire for personal collegiality or assumed equality that determines the course of the relationship. Moreover, given that the aim of medical treatment is the promotion of the health and well-being of the individual, in many situations it would be preferable for the patient to have a competent physician who disagrees with his/her personal values attending to his/her medical needs rather than having a sympathetic and collegial, but incompetent physician performing the task.

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[8] This point should be remembered when physicians attempt to impose their values or beliefs on patients when offering their own judgments about what the patient ought to do in various situations.

The priestly model[9] is the model that perhaps best represents the medical tradition. Here, the physician's role blurs the distinction between having the authority (and ability) to make decisions regarding medical issues (e.g., "You have A.I.D.S."), and moral issues (e.g., "You ought to inform your partner that you have contracted A.I.D.S.") Here, physicians make medical pronouncements about what is the case *and then proceed to make moral recommendations* what ought to be done about it. Here, the recommendations are offered not as bits of medical expertise on how to treat such and such an ailment, rather they are how to proceed regarding what the physician perceives is best for the patient. Veatch writes:

> In counseling a pregnant woman who has taken Thalidomide, a physician says, "The odds are against a normal baby" and "speaking-as-a-physician that is a risk you shouldn't take." One must ask what it is about medical training that lets this be said "as-a-physician" rather than as a friend or as a moral man or as a priest.[10]

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[9] The priestly model is also known as the "paternalistic model" (Ezekiel Emanuel & Linda Emanuel, "Four Models of the Physician-Patient Relationship", in Franscoise Baylis et al (ed.), **Health Care Ethics in Canada** (Toronto: Harcourt Brace) 1995.

[10] Robert M. Veatch, "Models for Medicine in a Revolutionary Age", *Hastings Center Report* (June 1972) pp. 5-7.

The mistake that is made is that the physician extends his/her medical expertise into the moral realm. The physician assumes that just because he/she has authority and knowledge in one area that he/she therefore has authority and knowledge in another. One such example of this is the difficulty surrounding the notion of "futility". For instance, what may be considered an act of futility to the physician may not be futile in the eyes of the patient. Moreover, the parties may be arguing at cross purposes when it comes to matters of futility; confusing the apparent objective nature of medically futile treatments with the subjective interests of the patient who simply wishes to tidy up his/her affairs.[11] Accordingly, the physician assumes a paternalistic role by "taking the locus of decision making away from the patient and plac(ing) it in the hands of the professional."[12]

Under the priestly model, the patient's decision-making is guided by the information presented by the physician but more significantly, the physician acts like the parent who tells the child what is in its best interest and then gives the child the "freedom" to choose what it wants. Since the parent is usually better informed and more qualified or experienced to make decisions, there is, in fact, very little room for the child to choose. This is specially the case if the parents consciously or subconsciously reveal their personal attitudes by their verbal and non-verbal mannerisms and the like thereby influencing the child's decision (e.g. "If *you* want to wear *that* "get up" go right ahead."). Likewise, physicians as "parents" may not reveal all the possible options available to their patients because of personal or professional attitudes regarding certain treatments or risks. Accordingly, the recommendations are verbal expressions of what course of action the physician has decided is best. The priestly model is an extension of the Hippocratic Oath and thus its primary concern is benefitting the patient and doing no harm regardless of what the patient requests. Furthermore, since the priestly model is rooted in the Oath, its grounding has already been rejected as morally illegitimate.

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[11] The issue of futility is one that is raised at length in chapter eight.
[12] Veatch, p. 13.

In this brief discussion of the profession-centered priestly model, we must point out that we can not place all of the blame of the continuation of this model upon the shoulders of the medical profession. Physicians, in general, do know more about the health of human beings than do lay persons. As mentioned above, this is why we tend to seek them out. Some patients prefer to leave the entire decision making process up to the physician. Some patients may believe that they are unable to make truly informed and wise decisions because they are not medical experts. Patients may not be well enough to think clearly or they may be scared and want to hand over such responsibility to the physician. Indeed, if we wished, we could push this description of the physician-patient relationship even further towards a more authoritarian model whereby the physician ceases to present "options" but instead simply dictates the best course of action for the patient with no regard for the non-medical interests of the patient.

Veatch pronounced the priestly model as being at the "opposite extreme" of the engineering model but, as we've just seen with the authoritarian model, we can envision other models that extend the decision-making powers of the physician and severely restrict the freedom of the patient to choose.

One other such model that goes "beyond" the priestly model is the "warrior" model.[13] Here we have a picture of the physician as a military officer doing "battle" against his/her enemies: illness, disease and injury. Just as with the authoritarian model mentioned above, the patient as a person gets lost. That is, the patient ceases to play an active or central role in the process. In this latest version, the patient is no longer the main concern but rather, the main, or perhaps the only, focus of the physician is upon the medical condition of the patient. Halt the disease and you win the battle; cure the patient and you win the war. The patient is nothing more than the battlefield upon which the General will either be victorious or defeated. Accordingly, this model removes all decision-making power from the patient and turns him/her into a passive vessel that happens to contain some illness or injury. As well, the relationship between the physicians and the other health care providers is one where the roles of the other providers are substantially diminished. The reason for this is because the "war-like" approach exploits their different skills, but may not capitalize on the training, experience and wisdom that the other attendants can offer: Nurses are seen as the soldiers in the trenches who simply follow, without question, the orders of their commander. However, the warrior model may have limited practical application in emergency situations where medical decisions and actions are urgently needed by patients who are incapacitated. Nevertheless, this model is clearly ethically unacceptable in cases where the patient is competent to make decisions. In sum, we must note that there is an important distinction to be made between the physician assuming the necessary leadership role that this model recognizes, and a dictatorial role that this model in fact promotes.

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[13] May, Willam, **The Physician's Covenant**, (Philadelphia: Westminster Press, 1983) pp. 63-86.

All the models that we have reviewed have been found unacceptable or limited for one reason or another. While some of them may contain elements that are practically useful and reflect certain attitudes of physicians (e.g., it could be easier for the physician to assume all responsibility of decision-making and act accordingly), these elements cannot be the only means by which a physician-patient relationship is derived and more importantly sustained from an ethical standpoint. A balance needs to be struck between moral idealism and pure efficacy. In response to the general imbalance of power between the parties, the liberal pendulum, if swung too far, develops into the consumer model where the patient is sovereign. In trying to make everyone appear as equal partners, the collegial model fails to recognize the actual demands that we put upon the medical profession. In recognizing the difference of expertise, the priestly, authoritarian and warrior models all, to one degree or another, continue to perpetuate medical paternalism.

The rejection of these models -- many of which have their beginnings in the morally illegitimate Hippocratic Oath, leaves room for their critics to move in with some form of a contract approach. The contract model is suggested as a viable interpretation of what would be an appropriate medical ethic that can incorporate some of the positive elements that can be drawn from the other models. These elements include some level of individual freedom to form reciprocal obligations (as taken from the consumer model), some sense of sharing decision-making responsibility and authority (as taken from the collegial model), the notion of special expertise (as taken from the engineering model) and an appreciation of the differing backgrounds and levels of expertise of the parties involved (as taken from the various physician centered models). The recognition that both parties should play active and direct roles in the physician-patient relationship is developed from the various remarks concerning the voluntary or involuntary relinquishment of a person's active participation, (be it the physician who is treated as a mere "technological tool" or the patient who is seen as the "battleground"). All of these elements, when taken together, are consistent with and/or support the development of a mutually beneficial agreement that is to be voluntarily adopted and sanctioned by the community.

What is new about modern medicine is the importance attached to the patient's perspective.
-Phillip C. Hébert, **Doing Right**[1]

CHAPTER FOUR

Medical Relations versus Contractual Relations

I. Introduction

Some who have rejected the Hippocratic Oath have also rejected the adoption of a contract theory of ethics as being a suitable replacement. Roger Masters, in "Is Contract an Adequate Basis for Medical Ethics?"[2], argues that a contract theory of medical ethics suffers from a variety of defects, as well, medical relations between the physician and patient do not look like standard contract relations. In "Code, Covenant, Contract or Philanthropy"[3], William May also rejects a contract theory of medical ethics on more theoretical grounds. His concern is not so much that medical relations don't look like contractual ones but rather that *it would not be a good thing* to base medical relations upon standard contractual elements.

In this chapter, I will attempt to present and address all the concerns of these two writers as I take their comments to be representative of the general objections against a contract theory of medical ethics. Where appropriate, I will try to treat Masters and May together when they share common objections. What we will see first is that Masters rejects the application of contract to medicine. His rejection, however, is due to his incorrect description of both contract and medical relations. Ultimately, most of his objections are found to be inapplicable. May questions whether contract would be a good model to adopt but in the end he favours covenants. I will then outline and discuss Robert Veatch's social contract theory, that is a reply, of sorts, to the various issues that are raised by the critics of contract. Unfortunately, Veatch's own work has its share of shortcomings and difficulties -- difficulties that will be resolved by the adoption of a liberal communitarian approach.

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[1] Hébert, Philip C. **Doing Right: A Practical Guide to Ethics for Physicians and Medical Trainees** (Toronto: Oxford University Press, 1996) p. 11.

[2] Masters, Roger "Is Contract an Adequate Basis for Medical Ethics?" *Hastings Center Report* 5 (December 1975) pp. 24-28.

[3] May, William F. "Code, Covenant, Contract or Philanthropy" *Hastings Center Report* 5 (December 1975) pp. 29-38.

II. Masters and Misconceptions

Given medical advancements and the scarcity of resources, Masters does not find it surprising that there is a demand for a better set of criteria for medical ethics.[4] He is also justly aware of the appeal of a contractual theory of ethics as a means of placing the burdens and benefits on the individuals who are directly involved. Nevertheless, he believes that the physician-patient relationship is not analogous with the essential nature of contracts:

> Unlike the contracts involved in buying a television set or a car, the purchase of "healing" -- while indeed necessary in the

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[4] Masters, p. 24.

> American medical system -- diverges from the general notion of contractual relationship in a number of crucial ways.[5]

In sum, these "crucial" differences are that 1) The "interest" of the patient is not comparable to the "interest" that the car buyer has because one's car doesn't have the same significance as one's life. 2) *Caveat emptor* cannot be appropriate in the medical model because patients' knowledge is *intrinsically* limited.[6] 3) The patient cannot shop around for a better price whereas they can comparison shop for a car. 4) Third-party payers, for example, insurance groups, not only structure the fee payments but also evaluate the "adequacies of treatment".[7] As well, government agencies play a large role in health care delivery and so infringe on the person's freedom to contract as he/she see fit.[8] 5) The physician works within social institutions which defines various treatment parameters thereby further restricting the options open to consideration and accordingly to contract. 6) The patient cannot consent to purchase medical treatment like one would in the purchase of a car or television since it is out of necessity and not want. Thus, patients cannot be said to "consent" to medical treatment as they consent to the contractual purchases of other goods. Finally, 7) the physician's role and surroundings (whether in a hospital or a clinic) creates a situation where the physician has a "virtual monopoly" over the patient. Thus a contract approach is an inappropriate vision of what happens in the physician-patient relationship.[9]

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[5] Masters, p. 25.

[6] Masters, pp. 25-26.

[7] Masters, pp. 25-26.

[8] Arnold Relman raises similar concerns in "What Market Values are Doing to Medicine", *The Atlantic Monthly* (March 1992), pp.99-106. He writes:
In a commercial market, consumers are expected to fend for themselves in judging what they can afford and want to buy. "Caveat emptor" is the rule. According to classical market theory, when well-informed consumers and competing suppliers are free to seek their own objectives, the best interests of both groups are likely to be served. Thus, in commerce, market competition is relied upon to protect the interests of consumers. This is quite different from the situation in health care, where the provider of services protects the patient's interests by acting as advocate and counselor. Unlike the independent shoppers envisioned by market theory, sick and worried patients cannot adequately look after their own interests, nor do they usually want to. Personal medical service does not come in standardized packages and in different grades for the consumer's comparison and selection. Moreover, a sick patient often does not have the option of deferring his purchase of medical care or shopping around for the best buy. (p. 100). We add to this, the impact of the development of Health Maintenance Organizations (HMO) in the United States. HMO's are contracted to provide all of the Medicare services to its subscribers and as such the role of the physician as advisor is becoming one of supplier and financial beneficiary. HMO's are under criticism for directly and indirectly controlling the amount of care that a patient receives as well as limiting the freedom of patients to choose which physician they wish to visit.

If we were to look for an overall theme in the above criticisms, we'd probably settle for the major theme of "individualism". Masters sees contract (but not medical relations) in terms of two parties mutually and voluntarily reaching an agreement without interference. We can highlight the distinction that Masters sees as being about the freedom to contract for an item such as a car versus the social, medical and institutional constraints placed upon the physician and patient. It is argued that these constraints cause undue interference with the patient's ability to consent to contract and therefore affect the nature of the relationship. Furthermore, with Masters' vision of freedom to contract, there is the assumption that it is a dyadic or one-to-one relationship, whereas the physician-patient relationship is apparently overshadowed by the intrusions of third parties. Accordingly, since medical relations aren't "individualistic" in the sense above, they aren't contract relations.

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[9] Masters, pp. 25-26.

Unfortunately, this argument is weak for a variety of reasons not limited to whether traditional contracts are all strictly dyadic relations. Multi-party contracts exist such as those that involve entertainment or sports figures. For example, a hockey player may sign an endorsement contract with a company on the condition that the company contract with a third party such as a charity organization to financially assist them.[10]

Masters believes that one would not buy medical treatment if one did not have to. However, if the existence of a contract rests upon what a person merely desires but does not necessarily require, then many everyday sorts of contracts are "defective" according to Masters' standards. To say that we would rather not have to contract for medical services does not entail that we do not in fact still have to do so. The existence of contracts is separate from the desirability of particular contracts. Masters is wrong in that we do contract for things we need. We are motivated to enter into contracts for a variety of reasons. We often buy things that we merely want but do not need (e.g., the latest electronic gadget) and we contract to buy things that we need but do not necessarily want (e.g., food, shelter, clothing, different types of insurance etc.). In the realm of health care, many women do not medically need to have breast augmentations, nor do men generally require hair plugs but many such individuals still purchase these cosmetic "goods" from surgeons. Hence, against Masters' picture of the world, we find that the interests of the buyer of health services are plausibly comparable to the interests of the buyer of other goods. The reason for this is because the object of one's subjective interests that one seeks out and purchases (e.g. that little red sportscar) often relates to one's own conceptions of the self and of self-fulfillment. Thus, we reject Masters' first criticism and subsequent presentation regarding the types of buyer's interests in relation to medical "goods" as not being analogous to buyer's interests and commercial goods.

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[10] My thanks to Mark Collins, LLB. for this example.

Masters' objection surrounding the intrusiveness of third-party payers may be valid but it does not impugn the contractual model, *per se,* rather it should be viewed as a point of contention about what sort of contract theory should be used. In other words, his objection should lead to questions of whether the classic liberal conception of contract that promotes individual contractors is better than a communitarian conception, which introduces community third party participants. If the liberal contract approach is dissimilar to the medical relationship, this does not entail that all other contractual approaches are equally inappropriate. Masters' concerns do not have to result in the wholesale rejection of contract, rather they can be viewed as a signal for the need to adopt a more broadly based theory of contract, which includes the interests of third parties, as well as the imposition of some restrictions.

Since third parties are sometimes indirectly responsible for medical payments in Canada (e.g., provincial insurance plans are funded through general taxation), some infringement upon the freedom of individuals who put themselves in needless risk may be justified. The requirement to have automobile insurance and to be subject to various stipulations within that policy including an adherence to seatbelt and helmet laws, makes more sense when others are forced to pick up the medical costs for those who suffer injuries as a result of their failure to comply with the legal impositions. In a system where the individual is personally responsible for purchasing his/her own medical coverage (e.g., through conventional insurance policies or Health Maintenance Organizations), the question of community resource allocation remains applicable since third party insurance premiums may increase.

Related to the acknowledged complexity of contract relations, Masters is right to note that the physician-patient relationship is restricted by social institutions and agencies but so too are other types of relationships. It is wrong to maintain that the classic liberal *laissez-faire* contract dictates that the operations of the marketplace are to be completely free from all external constraints. All (legally binding) contract agreements work under some type of external mechanism. Thus, many contracts cannot be accurately described as being completely "free". Companies must, for instance, abide by various honest practices including disclosure. Food companies must disclose the contents of their products and what the contents may consist of is determined by regulations.

"Regulation", as defined by Moran and Wood, "is the activity by which the rules governing the exchange of goods and services are made and implemented".[11] Furniture, cars, housing and clothing all have safety standards that are vigorously enforced. Under classic liberalism, "buyer beware" is a useful warning but this does not entail the adoption of an "anything goes" attitude whereby the customer must possess vast amounts of knowledge about both the product and the vendor and must also be on guard against every possible unfavourable transaction. Car manufacturers must provide safe vehicles that also meet certain pollution standards. There are consumer watchdogs to check that consumers do not get gouged by inappropriate pricing and anti-trust laws to ensure fair market competition. There are government regulations concerning credit card interest rates. The Landlord and Tenant Act restricts the various obligations and freedoms of both parties. The list can go on and on but the point is clear: outside agencies (primarily state agencies) currently put parameters on what contracting parties may or may not do although the degree to which they have power to regulate contracts varies considerably. Even though there are restrictions and intrusions, contracts still exist and are effective means of exchange:

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[11] Moran, M. and Wood, B. **States, Regulations and the Medical Profession**, p. 17.

> (Regulation) is the foundation of social life. Every kind of market has to be regulated. This can include: the control of market entry and exit, of competitive practices, market organization and of remuneration."[12]

Although Arnold Relman is right to suggest that *caveat emptor* is the rule in classic market theory,[13] the freedom that is attached to this notion is a freedom to choose wisely or foolishly. It is not a freedom intended to support deception and mistreatment. Accordingly, we continue to find fault with Masters' vision of standard contracts since such contracts are governed by a set of legal parameters.

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[12] Moran and Wood, p. 17.

[13] Relman, A. "What Market Values are Doing to Medicine", *The Atlantic Monthly*, (March 1992). See also footnote 6 above.

What about emergency cases where William May notes that the marketplace is unable to ensure consumer protection?

> (T)he crisis circumstances under which medical services are often needed and delivered does not always provide the consumer with the kind of leisure or calm required for discretionary judgment. Thus normal marketplace controls cannot be fully relied upon to protect the consumer in dealings with the physician.[14]

There is no reason why the medical profession must be singled out for this sort of worry. If I am driving down the David Thompson highway, a noted lonely stretch of road in Alberta, and my car dies, I may have no other choice than to rely upon the individual who finds me. If they take me to the only gas station within 100 kilometers, then I will be at the mercy of that auto mechanic. Notice that this situation does not provide me with the protection that I may otherwise have if I were able to choose among various potential repairers of my automobile. In other words, I would be in a similar sort of situation as if I had been in a medical crisis since I am solely dependent upon one provider and I cannot make price comparisons or compare the quality and timeliness of the work performed.

If I am upset and I don't have the leisure to wait for another tow truck or mechanic, my decisions may be made out of duress. Given that the gas station is the only one around, I am forced to enter into a contract with the attendant. Even though my options are hindered by the lack of competition, I do have legal recourse if the mechanic takes advantage of the situation. In cases of life and death medical emergencies where the patient is distressed or incapacitated, a medical contract may still exist. As we will discuss later, some common medical situations can be considered representative of a unilateral contract where consent by the other party is not required. A professional promise to assist in crisis circumstances (e.g., where the patient is incapacitated and is in a life-threatening situation) is a unilateral contract with the individual. The community as a whole relies upon such a contract being carried out.[15]

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[14] May, p. 35.

We must accept that Masters is partially correct regarding the fact that physicians have a virtual monopoly on the services that they provide. Nevertheless, Masters' own hesitation regarding monopolies is not clearly expressed. I suspect his concerns are that monopolies are too powerful and that they can force potential contractors to accept any offer that is presented. As a consequence of this limitation, the notion of voluntary "consent" or rather, the freedom *not* to consent is lacking since monopolies deny the individual the opportunity to choose whom to contract with. Furthermore, if a person is entering a contract out of duress or undue influence, or is forced to enter the contract out of necessity, then there is just reason to be concerned that the contract will not be legitimate. However, just as there is a distinction between a person's wanting to contract and a person's needing to contract out of medical necessity, simply because a profession has a monopoly on its services, does not entail the impossibility of our being able to contract with them, nor does it necessarily deter our willingness to do so. Whether an individual or corporation has a monopoly is not a determining factor as to whether one can form a contract with the said individual or corporation. People form contracts with the only grocery store in town and with the last gas station on the highway even though these businesses have a virtual monopoly in their respective markets. One could possibly force the issue and claim that people *do* have the option *not* to purchase items from the only food store in town as they could plant their own garden and raise their own livestock. Obviously, however, these "choices" are not very attractive or feasible for the vast majority of the public.[16] Moreover, it is also the case that we form contracts with other sorts of professionals (e.g., lawyers and engineers) who may be said to have monopolies in their areas. Thus, the mere fact that a monopoly exists in a particular field does not preclude that contracts are impossible. Instead, what the existence of monopolies does tell us is that safeguards should be put in place to protect weaker parties who do not have similar resources at their fingertips.

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[15] See Chapter 6 for a more complete discussion of legal contracts.

Like Masters, May also expresses a similar distaste for monopolies. May argues that having the freedom to choose between various vendors of services provides a self-regulating mechanism in contract. However, "normal marketplace controls cannot by fully relied upon to protect the consumer in dealings with the physician;"[17] and "freedom of choice needs to be expanded for the patient by an increase in the number of physicians and paramedical personnel." [18] May's suggestion to increase the number of physicians won't placate Masters, since the proposal suggests that the monopolistic corporation should become even larger in order to provide greater choice. Unfortunately, the 'choice' that this expansion would provide customers may simply be more of the same since having more physicians may be like having more McDonald's restaurants -- more people can be served but the selection doesn't change significantly.

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[16] As well, the simple existence of a monopoly is not a factor in determining whether said monopoly is good or whether an individual should consent to contract with it. Indeed, monopolies are not inherently evil since their having a grand financial base or access to a massive resource pool can be beneficial to the consumer who is interested in the low cost, efficiency and variety of various goods and services. If the monopoly can provide more comprehensive service, choice and price optioning then the monopoly may be better than competition. Governments can hold monopolies over some services and some of these monopolies are commonly considered good (e.g., medical insurance) while others may be bad (e.g., car insurance).

Although we have been defending the concept of a monopoly, if we look closer at the "physician monopoly", we recognize that, in reality, the patient has more choices than originally conceived. Patients have the right to choose which physician they seek to consult. Patients may seek the opinion or services of other physicians if they are not happy with the first physician's response. Individuals may also seek[19] non-traditional methods of treatment or preventative medicine via community health clinics, home care, private services, midwifery, chiropractory, acupuncture and other homeopathic avenues.

Masters and May both agree that there is an enormous imbalance of knowledge which can affect the fairness of the physician-patient contract. Due to this vast discrepancy, May argues that internal checks are required while Masters strongly insists that there cannot be a fair contract.

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[17] May, p. 35.
[18] May, p. 35.
[19] However, some of these fields may not be recognized or covered by medical insurance.

Here May envisions that the imbalance within the physician-patient relationship may be rectified if we look to other sorts of contracts. Masters believes that the physician-patient relationship is not balanced like a typical contract relationship, and so the physician-patient relationship is not a good candidate for contractual status.

The view that standard contracts, unlike potential medical contracts, are generally balanced in terms of the parties having roughly similar resources, skills and knowledge is simply mistaken. We've already partially addressed the issue by noting that one can enter contracts with a monopoly. Moreover, the analogy between medical and contractual relations remains strong since many of the everyday sorts of contracts we enter into have imbalances of knowledge and/or skill. In fact, we enter many sorts of contract relations *because* of the imbalances of knowledge and skill. If we knew how to fix the air conditioning in a car or how to replace outdated wiring in a house, then we wouldn't have as great a need to hire someone to do it for us. Since a car-owner's or home-owner's knowledge of repairs is typically less than the service provider's, there are standards that must be met by the provider to ensure that the owner is protected. For example, there is disclosure of relevant information and costs to ensure that consumers are not defrauded. This information also helps to ensure the continued good name of the particular professional trade. Furthermore, contract law gives the harmed party the recourse to sue for damages if there is mistake or misrepresentation. It also has guidelines to cover questions of undue influence which might arise in relationships where one party has a far greater amount of knowledge than the other and is able to use this knowledge to the detriment of the other party (e.g., by not giving reasonable disclosure).

In conclusion, Masters' remarks regarding the dissimilarity of contracts and medical relations are not persuasive. He fails to appreciate the basic characteristics of general contracts of the sort that people enter into everyday. The existence of individualism, while present, is less of a threat in normal contracts than is supposed since some regulations are already established and accepted. Nevertheless, just because medical relations may not differ that drastically from contractual ones, we cannot automatically conclude that it would be good to develop or promote medical relations along the lines of contractual relationships.

III. May and Minimalism.

May rejects the contract theory of medicine on the grounds that he believes it produces a professional who is unwilling to go that "extra mile" for the patient. May charges that the contractarian position reduces the physician-patient relationship to a commercial venture: "Do no more for your patients than what the contract calls for; perform specified services for certain fees and no more".[20] This "minimalism" of contract produces a "professional too grudging, too calculating, too lacking in spontaneity, too quickly exhausted to go the second mile with his patients...".[21] Whether this would be the case is not clear. However, perhaps part of the reason for this perception of a lack of care may be due to the continued development of information and skill that requires more and more medical specialization. Arnold Relman writes:

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[20] May, p. 35.

[21] May, p. 35.

> In an earlier and less technologically sophisticated era most physicians were generalists rather than specialists. They had mainly their time and counsel to offer, commodities that commanded only modest prices.[22]

In addition to the expansion of medical knowledge, the attitudes of the modern patient may also be partially responsible for the passing of the traditional role of the family physician to "go that extra mile". It is reasonable to suggest that the primary reason for initiating a physician-patient relationship is the need or desire of the patient to receive medical attention. The competent person as a patient is usually interested in one thing: not being a patient for any unnecessary length of time. In other words, it is in the best interests of the patient to have their health concerns addressed. Thus, patients tend to seek medical attention in order to be cured or healed, and if that is impossible, then they want their suffering eased. Accordingly, if my well being is my primary interest then whether the treatment I receive is done impersonally is of lesser objective interest to me than its being done competently. The emphasis on competency of skills is especially relevant with emergency situations where there is a sense of urgency. Analogously, we seek out experts in other areas to assist us with our other needs. That a car mechanic is of a sunny disposition and is interested in his/her customer as a person will be an asset to both individuals if the relationship continues beyond resolving the immediate problem. However, customers are not paying the mechanic for their friendly banter. Rather, it is the role of the mechanic to fix cars and it is this role that we are primarily seeking given our automotive needs. We are paying the mechanic to fulfill his/her role as an expert. It is in our interests that he/she fix the car, fix it well and fix it quickly.

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[22] Relman, A. "What Market Values are Doing to Medicine", p. 101.

This consumerist perspective tends to perceive all provider-patient relationships as being akin to specialist-patient relationships. However, this approach is too narrowly defined since different medical needs require different roles to be played by the individuals involved and thus, the specialist has a different role to play than the family practitioner. Family practitioners or "generalists" tend to seek out comprehensive pictures about their patients' overall well being while specialists tend to be more centered on treating the particular ailment. This difference of focus does not deny that the "bedside manner" of any physician may affect how the patient internalizes and processes the information that he/she receives. It is important for the two parties to realize that they are both involved and affected by the outcome of the situation. Being personable can make the patient more at ease and more willing to discuss the reason(s) for his/her having to form the relationship. For example, a patient who has caught a sexually transmitted disease through an extra-marital affair might be more open to a compassionate, non-judgmental physician than one who is cold and clinical. The child who feels relaxed in the physician's office may be able to better describe the sorts of pains it is feeling. The physician who has a good rapport with his/her patient and knows the patient's history, fears, family etc., has a greater opportunity to communicate more effectively and thereby establish a honest dialogue which enhances the patient's ability to make an informed decision. Accordingly, the increase in special medical knowledge does not necessarily lead to a decrease in personable care. Furthermore, a contract theory of medical ethics does not encourage or support a minimalist approach towards the patient as it affects the ability of both parties to achieve their inter-related goals. Incorporating a notion of care (as exemplified by "going that extra-mile") within the confines of the provider-patient relationship may be beneficial but it may just represent supererogatory acts on behalf of the physician. Just as we would continue to return to the competent mechanic who we like and who goes beyond their duty to fix our car, so too would we most likely return to the competent physician (be they a general practitioner or a specialist) who treats us and cares about us as a person.[23]

The collegiality of the physician can be realistically portrayed as being beneficial to the contract relation because it can assist in the creation of an atmosphere of trust and cooperation. Indeed, nothing within the notion of contract precludes the inclusion of traditional roles and values of family practitioners. The family practitioner who doesn't know his/her patient as a person but is just interested in addressing the patient's ailment is not fulfilling his/her duties. The more information that the physician can acquire about the patient, the better the opportunity to understand the patient's particular perspective and interests. The greater the understanding, the more efficient the process can be in terms of assisting the patient in achieving a satisfactory outcome. Thus, such elements are to be stressed in contract relations.

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[23] It is interesting to note that the trend for medical graduates to become general practitioners is slightly increasing as compared with those graduates becoming specialists. In 1992 there were 28,471 GP/FM and 25,365 Specialists in Canada (excluding interns and residents). Source: Canada. Health Canada. "Health Personnel in Canada 1992", (Ottawa, 1995) p. 182. In 1973, there were 12,963 GP/FM and 14,341 Specialists (excluding physicians not in private practice). Canada. National Health and Welfare. "Canada Health Manpower Inventory 1974" (Ottawa: n.d.) p. 116. David Keane, PhD., Research Associate, Programmer for Educational Development, Faculty of Health Sciences, McMaster University suggests that the tipping of the balance towards General Practitioners is probably due in part to the increase in the number of women who have entered the profession since the 1970's. Sources and data kindly provided to the author by Dr. Keane.

Another component of May's attack against the apparent minimalist and rigidness of contract is that the health of the patient is unpredictable. Unforeseen illnesses or accidents occur which cannot be specified in advance for each patient. Accordingly, such illnesses may require treatments that exceed those "anticipated in a contract."[24] May then argues that contracts unjustly promote "defensive medicine" whereby the physician orders procedures to be done which are not substantiated by the patient's condition in order to avoid possible lawsuits. A combination of these two points results in the development of a contractarian paradox. The physician does too little because it is not "in the contract" and the physician does too much in order to avoid malpractice suits.[25]

A broad clinical practice policy may be the answer to May's paradox. An open-ended policy that would cover the "unpredictable" could be incorporated into a more inclusive contract. No one would deny that accidents happen and that there are inherent risks in all medical procedures. Even the best physician cannot predict or avoid some tragedies and, thus, it would be unjust to hold him/her strictly liable for unforeseen complications.[26] We can also argue that the community ought to step in to the situation by setting up reasonable guidelines as to what the proper diagnostic tests should be and how medical procedures ought to be performed. By doing so, the community eases the physician's perceived need to overcompensate and, as well, the community guidelines provide adequate information to the patient. If the physician meets the guidelines then there is less need to run unnecessary tests and it becomes very difficult for the patient to sue for malpractice if an unforeseen complication arises. This action can reduce costs and allow greater access to medical treatments that might otherwise be over-taxed by defensive medicine. The implications of instituting this sort of policy upon the practices of physicians and the freedoms of patients will be discussed at length in the final chapter. While it would be nice if physicians did act above and beyond the call of duty, they need not do so. Still, as noted above, by going "that extra mile", they are able to justly promote the contractual relationship.

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[24] May, p. 35.
[25] May, p. 35.

Let us turn to consider May's final objection which had the potential of being the most troubling had we not already addressed a related issue of Masters'. May asserts that under a contract theory of medical ethics a patient might conceivably waive certain rights, rights which should not be relinquishable.[27]

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[26] As we will discuss in a later chapter, it would be equally inappropriate to claim that we should not attempt to fully inform the patient of the treatment before gaining his/her consent on the grounds that we 'can't predict the unpredictable'.

[27] May, p. 35.

> Normally conceived, ethics establishes certain rights and duties that transcend the particulars of a given agreement. The justice of any specific contract may then be measured by these standards. If, however, such rights and duties adhere only to the contract, then a patient might legitimately be persuaded to waive his rights. The contract would solely determine what is required and permissible. An ethical principle should not be waivable (except to give way to a higher ethical principle). Professional ethics should not be so defined as to permit a physician to persuade a patient to waive rights that transcend the particulars of their agreement.[28]

If this were indeed the case, there would be good cause for rejecting a contract theory. May's challenge is based upon an extremely individualistic and self-reliant (or self-contained) model of contract that is only subject to the parties' own agreed upon constraints. Yet, few would allow contracting parties to be able to waive their fundamental rights to such things as security of the person. If the rights should not be waived for ethical reasons, then there is strong evidence to suspect that a contract that incorporates such an occurrence is either illegal and, hence, not enforceable or is not a contract at all. However, even with the most basic *laissez faire* contracts there are guidelines imposed upon the contracting parties, for example, one cannot enter into a binding contract that involves giving up the right to personal liberty as with self-enslavement, or which involves violating the duty not to kill another person.

Even within a *laissez-faire* system, what one is free to do in a contractual relationship is guided and shaped by various ethical, legal and socio-political principles and standards. These constraints are the ones that are contained within a liberal notion of a just society. In fact, under liberalism, the aim of creating a marketplace where freedom to contract "rules supreme" may be best achieved by a practice of protecting the welfare of the contracting parties. Protecting contracting parties ultimately allows for the continuation of present and future contractual relations. Accordingly, the minimalist nature of contracts has been over-stated by May.[29]

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[28] May, p. 35.

The above sorts of objections by Masters and May are representative of those posed by the critics of a general contract approach to medicine. I have suggested that a general contract theory can respond satisfactorily to many of their criticisms, as they are often the result of misinterpretations and misrepresentations. All in all, the general complaint of Masters and May revolves around their dislike for the individualist or non-restrictive nature of contract, as well as the minimalist or rigidness of contract. While we have tried to address some of their concerns on these matters, there may be lingering doubts as to whether contract law should be prescribed for what ails the physician-patient relationship.

In attempts to move beyond contract, some consider covenants as a solution to the problems brought about by the Hippocratic tradition. Masters and May have significantly differing viewpoints when it comes to understanding the concepts of contract and covenant. Masters does not make a distinction between the two concepts writing, "(t)he notion of a 'contract' or 'covenant' as the origin of ethical duties is not, however, a new one."[30] Accordingly, Masters believes that covenants, like contracts, will not suffice as an adequate interpretation of the physician-patient relationship. May, on the other-hand, draws a significant distinction between the two and presents a more favourable attitude towards covenants due to their apparent ability to avoid "minimalism".

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[29] Resolution of the issue of minimalism will be presented within our discussion of the role of nurses and physicians as presented in Chapter 8.

IV. Covenants are not Contracts; Gifts are not Obligations.

In the previous section, we have argued that the charges against contracts as being inappropriate for the physician-patient relationship are unsuccessful. However, in recognizing the problems with the Hippocratic Oath, some critics have turned to covenants as a means to capture the best about physician-patient dealings. May favours covenants over contracts because:

> ...it would be unfortunate if professional ethics were reduced to a commercial contract without significant remainder...(T)he notion of contract suppresses the element of gift in human relationships.[31]

and

> (t)here is a more donative element in the nourishing covenant ...which is important in health care.[32]

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[30] Masters, p. 24.

[31] May, p. 33.

[32] May, p. 34

Against May's views, it is my contention that a contractual theory of medical ethics promotes a fair balance between the physician and the patient while a covenant theory maintains and extends the old connotations of physician paternalism which places the principle of beneficence above that of autonomy.

Covenants have religious overtones. In Judeo-Christian teachings a covenant exists between God and Humankind. God has given the gift of life to human beings and with this comes an exchange of promises that affect one's entire life: God will love us and we will worship Him most highly. A comparison between physicians and God is understandable since God and the physician are seen as having the power over life and death. The power to heal can appear to be almost magical and mysterious suggesting that the physician has some access to powers that the lay person does not. Indeed, it has become a cliché to accuse physicians of trying to "play God" -- not only in terms of trying to save those who cannot be saved, but also in terms of being self-righteous. This is not the sort of image that assists physicians in regaining lost respect with their patients.

The religious aspect or connotation associated with covenants does nothing to remove the spectre that haunts the physician's noble and sincere actions. God is characterized as the Holy Father and, like a parent to a child, God knows what is in our best interests. Casting the physician-patient relationship as being one of a covenant means that we should consider the physician as being God-like, or priest-like or as a parent to a helpless child. All of these roles raise fears of a medical paternalism that injects inappropriate value judgments into the medical process.

May points out that the ancient notion of covenant involves:

> 1) an original experience of gift between the soon-to-be covenanted partners; 2) a covenant promise based on this original or anticipated exchange of gifts, labors, or services; and 3) the shaping of subsequent life for each partner by the promissory event.[33]

The above three elements could be interpreted as a description of the sort of relationship that a physician has with his/her teacher. The medical student receives the gift of medical skill, training and knowledge. The student also makes a promise to act in a certain professional manner as so instructed by the medical profession. Finally, there is the life-long intimate connection between the principles that the individual maintains as a physician and the moral principles that he/she maintains as a member of the profession and as a member of society. Nevertheless, we could easily put forward another reading of the teacher-student relationship as one that could be interpreted as being a contractual relationship. The student pays his/her fees and the teacher instructs the student and each has specific and common responsibilities and rights associated with his/her role.

Regardless of the last reading presented above, May's characterization of the elements contained within the medical teacher-student relationship does not adequately carry over to the physician-patient relationship. To put it bluntly, for a physician to conceive the application of his/her medical knowledge to his/her patient as the giving of a gift smacks of moral and professional high-handedness.

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[33] May, p. 32.

The physician-patient relationship is not one based on gift giving. Gifts are given out (in part) due to a desire by one person to make another person happy which, in turn, can satisfy the gift-giver's self-interest. Ideally, the type of gift is selected by the gift-giver depending upon what he/she thinks would bring the other person the most pleasure. Thus, some acts of gift giving contain paternalistic motives; "I give you this because I believe it is what you need most". Of course, gifts may be requested (e.g., the recipient may ask for a Christmas gift in a certain colour or size) they can also be refused, and, in this way, the recipient has some minimal amount of power. Accordingly, the giving of a gift in these cases is not paternalistic. However, it remains the case that one must be offered a gift before one can refuse it. Furthermore, while the recipient may, in fact, receive that which truly makes him/her happy, he/she tends not to have any say in what the gift consists of as the gift is given on a whim of the giver. If this description of gift-giving is accurate, then mapping these characteristics onto the physician-patient relationship will not foster an acceptable and/or balanced relationship.

With the giving of gifts, there is no sense of obligation on behalf of the gift-giver. The gift-giver does not *owe* it to the recipient to provide the recipient with the gift since it is up to the gift-giver to decide whether or not to offer it. As such, some acts within the medical arena are acts of gift giving in the truest sense. For example, organ donations are rightfully perceived as being acts of altruism. Recipients do not have a right to demand that they be provided with gifts --whether the gift is jewelry or kidneys. The gift-givers are not duty-bound to comply with any or all requests. This image does not parallel the situation that we are dealing with since patients have the right to some forms of medical treatment and physicians have a reciprocal obligation to provide it. Physicians who provide medical assistance and receive compensation for that assistance are not gift-givers.

It is also inaccurate to conceive of the physician's administration of medical treatment to the patient as having completely originated with the physician. The community provides great financial subsidies for his/her medical training. Ultimately, the medical costs are paid by the members of the community who, in the name of that community, rightly request symbolic repayment of the debt via receiving competent medical health care. Accordingly, to call medical treatment a gift from the physician is a misnomer since the potential recipients of the gift have already collectively paid for it, and, thus, are owed the services of the physician.

> The professional education of physicians is heavily subsidized, because tuition, even in the private medical schools, does not nearly cover the costs of educating medical students. Furthermore, the information, tools, and techniques that physicians use to practice their profession are usually developed through publicly supported research. Finally, hospitals provide physicians with the facilities and personnel and often even the specialized equipment they need to treat their hospitalized patients, thus relieving doctors of many of the kinds of overhead costs that businessmen must pay.[34]

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[34] Relman, A. "What Market Values are Doing to Medicine", p. 100.

The idea of debt repayment is carried through by May in his preference of covenant over a professional code based ethic. Although May rejects contract in favour of covenant, both contract and covenant involve notions of promissory exchanges. Accordingly, the recognition of indebtedness that the public has to the physician for his/her medical services and that the physician has to the public for their support removes the unsatisfactory "top-down" approach associated with gift-giving. While some physicians might find treating the standard "everyday" illnesses as tiresome and burdensome, it is a simple truth that without the patient there could not be the physician. Physicians need patients in order to practice medicine.[35] Recognition of this fact by the patient should provide some level of psychological reinforcement and serve as a useful reminder to physicians who treat patients with an air of disrespect and condescension.

Contracts, unlike covenants, restore respect to both the physician and patient since both parties are to be seen as roughly equal agents entering into an agreement. By invoking contracts, physicians are served in that they need not be perceived by the public as paternalistic authoritarians who set the rules and maintain a monopoly over the administration of their skills. Instead, within the realm of contractual arrangements, both physician and patient are justly portrayed as self-interested individuals who have entered into a cooperative adventure that involves sacrifice, benefit and the exchange of information and services. Such arrangements will require informed consent and recognition of the inherent strengths and limits associated with each role.

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[35] Practice, in both senses of the term. That is, 'practice' as in 'learning how' and 'practice' as in working in the field of medicine.

While we have agreed with May's assessment that there is an important distinction between contracts and covenants, we have rejected covenants on the grounds that they perpetuate various myths associated with the medical profession. However, it is noted that Robert Veatch, whose work **A Theory of Medical Ethics** is intended to answer the sorts of concerns raised by Masters and May, construes his version of a contract theory of medical ethics as being very similar to a covenant theory. Veatch sees little difference between the two and adopts a social contract theory to meet the challenge of providing a more acceptable alternative to the Hippocratic tradition.

V. Veatch on Contract

Robert Veatch's **A Theory of Medical Ethics** is an attempt to not only replace the Hippocratic Oath but also to answer the concerns regarding the individualist atmosphere which would exist when physicians and patients are permitted to contract in a non-restricted marketplace.. As well, Veatch hopes to resolve the impending minimalism that would exist outside May's covenant framework.

Veatch's political contract project rises out of the ashes of the Hippocratic tradition. As we have seen, the Hippocratic tradition is unacceptable since it is based on the view that a medical ethic can be founded on a professional code that is articulated and developed by, and for, the members of that particular profession. Instead, the basis for an acceptable medical ethic should have the fundamental involvement of those it affects. These individuals are the members of the community who, directly as patients or indirectly as taxpayers, are affected by medical care. Accordingly, it is not just an understanding among the professionals in question, rather it is an agreement between professionals and society at large.

For Veatch, having the physician and patient come together to form a binding relationship as two individuals in mutual agreement is not enough. The first reason for this is that it would be difficult to find physicians and patients who agree on all matters.[36] Secondly, there remains the difficulty about how to characterize emergency situations where it is clear that one of the parties has not voluntarily agreed to enter into the relationship. Thirdly, (with implicit allusions to Masters' concern over "individualism") Veatch argues that two individuals who enter an agreement could agree to do things that we would typically, or common-sensibly consider immoral or unethical. Hence, in order to avoid the "anything goes" approach, there is a need for a framework of constraints.

In favoring a social contract basis of medical ethics as the means to develop the framework of constraints, Veatch does not offer a preference as to how the contract is formed. For some, the moral community generates the formation of the contract, while others see the formation of the contract as a theological discovery that is created by God or an ideal observer. The important issue, states Veatch, is not whether the contract is generated or discovered by the original group, but rather that it exists.

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[36] Recall our previous discussion concerning the collegial model.

Veatch's approach to a contract theory may be seen as a political approach and not a legal one. Veatch does not like the legalistic connotations that come with the term 'contract' since he fears that it implies a cold minimalist approach to the physician-patient relationship. Veatch also implicitly maintains individualism is unacceptable. Sounding much like the earlier critics of contract theory, he writes: "I have concerns that medical ethics in a contract perspective might be taken to be limited only to legal relationships occurring between two isolated individuals."[37] He is right to want to reject such a starting point.

Veatch acknowledges May's covenant theory which entails the acknowledgment of the Hippocratic obligation to continue to excel in medical expertise and the sense of duty that transcends the minimal requirements of contract to include societal concerns.[38] Veatch's own attempt to resolve the minimalist problem is by simply stating that covenants and contracts are basically the same.[39] Hence, he characterizes his view as being both contractual and covenantal. In other words, Veatch's contractual theory of medical ethics involves a particular kind of contract emphasizing moral bonds and the spirit of fidelity that exists in such things as a marriage contract.[40] Such a bond is taken to promote the notion of a caring relationship.

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[37] Veatch, p. 7.
[38] May, p. 36-38.
[39] Veatch, p. 7.

Veatch's response to the question, "What sort of contract is formed?", is to argue for a triple contract theory.[41] Veatch's triple contract begins by establishing the most basic principles for human interaction.

Veatch sees the basic contract as expressing a moral community, bound together in reciprocal pledges of trust and loyalty.[42] The basic contract lays out the fundamental principles that are applicable to all parties. According to Veatch, these fundamental principles are beneficence, contract keeping, autonomy, honesty, avoiding killing and a principle of justice.[43]

After the basic social contract has been articulated, a second contract between the society and the profession is developed to spell out the unique role-specific duties of the lay persons and professionals. The only limitation of the second contract is that it cannot contravene the morality of the prior, more basic social contract. Finally, within the context of these two contracts, individual professionals and lay persons have the opportunity to spell out in further detail the terms (moral and otherwise) of their relationship. The result is a "triple-contract theory of medical ethics" that is, in principle, accessible and applicable to all. Individuals are free to contract so long as they work within the constraints of those various principles that rational agents would agree to.

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[40] Veatch, p. 7.
[41] Veatch, pp.108-137.
[42] Veatch, p. 125.
[43] Veatch, p. 11.

Veatch's development of the original contract is rather loose, as he is not seriously interested in how the social contract begins. Rather, he is more concerned about what it contains.[44] Still, he is sympathetic towards the Rawlsian veil of ignorance whereby the original contractors are to discover or *invent* the guiding principles with no personal knowledge of anyone's social status.[45] Given this state of affairs, claims Veatch, the original contractors might reasonably agree to a principle of beneficence because "it is in their best interests".[46] However, beneficence cannot be the only principle. He believes that "reasonable people might not opt for that principle (of beneficence) alone",[47] since, for example, having a principle of beneficence as the only right-making characteristic of an action rules out the ability of autonomous agents to refuse objectively beneficial treatments. Another reason why reasonable people might not opt for beneficence as a sole principle is that it is linked to the Hippocratic Oath and our associated concerns with it.

Veatch tries to put himself in the position of the hypothetical contractor and he decides (with very little supportive argumentation) that since one must consider the interests of all as being equal, promise-keeping, or contract-keeping is a right-making characteristic independent of the consequences.[48] The extent to which a promise or contract to keep confidentiality can be maintained or broken is something that must be decided by the community.[49]

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[44] Veatch, p. 124.

[45] Veatch, p. 120.

[46] Veatch, p. 145.

[47] Veatch, p. 146. This is also a typical example of the somewhat unsatisfactory way in which Veatch continually hedges his bet. Instead of putting a strong philosophical position forward and arguing that rational persons will, or ought to adopt such and such principles, Veatch continually backs down by suggesting that it is only a reasonable possibility that rational persons *may* do such and such.

> The contractors inventing or discovering the principles have a clear choice...they can opt for the principle of promise-keeping without exception or they can opt for the principle that promises should be kept unless it is beneficial to break the promise.[50]

Such a constraint must, nevertheless, take into account the next principle: the principle of autonomy.

Veatch believes that a principle of autonomy is a basic good. Moreover, he believes that the original contractors need to acknowledge the freedom of the contractors even before they contract. While he is aware of the difficulties that this point creates with a social contract theory, since it suggests that the contractors have already established principles prior to their initial agreements, Veatch simply claims that the original contractors would agree to a principle of autonomy. The only question worth considering, according to Veatch, is not whether the contractors would have a principle of autonomy but whether the principle of autonomy (or freedom)[51] is absolute.

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[48] Veatch, p. 183-185.

[49] Veatch, p. 187-189.

[50] Veatch, p. 181.

[51] Veatch uses 'autonomy' and 'freedom' interchangeably. See Veatch, Chap. 8. pp. 190-213.

Veatch's argument in favour of including a principle of autonomy amounts to his commenting that it has been affirmed, time and time again, by other social contract theories. Veatch's own principle of autonomy places limitations on what persons may or may not do. That is, one's autonomy can be limited if it interferes with the liberty of others.[52] Even though "rational contractors" would never permit beneficence to take precedence over liberty, Veatch believes that "society has the right to intervene to protect the welfare of individuals who are substantially non-autonomous, whose actions are essentially non-voluntary."[53]

Contractors might agree to paternalism if actors are "engaged in potentially seriously harmful acts to themselves and there is *prima facie* evidence...that those persons do not understand what they are doing."[54] The degree of permissible interference is limited to a minimal infringement in order to determine whether the person was acting autonomously. Here, Veatch seems to be equating autonomy with the related, but different ideas of competency and voluntariness. One needs to be careful about how broadly construed the term 'voluntary' is used. We must recognize at a person may act voluntary even though they are being acted upon, or their decisions are being affected by, external forces such as stress, emotions, social upbringing, social class and economic situations, etc. Minor levels of stress may be irrelevant to our ability to decide what is in our interests, but extreme levels of stress can be incapacitating and dangerous to our own welfare. Furthermore, while it is the case that the original contractors are making decisions that will affect all persons, it is significant that the incompetent person (whose right to autonomy is perhaps at the greatest risk) is not included or represented in the original contract. This is disconcerting since the individual or his/her representatives are unable to participate in determining which principles are adopted and which interests are to be promoted. Accordingly, one must question how engrained the concept of paternalism is within the original contract.

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[52] Veatch, p. 195.
[53] Veatch, p. 195.
[54] Veatch, p. 195.

The principle of autonomy allows for individual contractors to surrender their freedom within certain parameters and, as such, it provides further evidence against May's concern regarding contracting parties giving up certain rights.[55] Furthermore, the principle of autonomy allows physicians the right to not engage in actions that they find morally distasteful (e.g., perform abortions). However, according to Veatch, if physicians have this right then "society will have to assure itself that other professionals will be trained and available to provide services considered essential."[56]

Veatch appeals to community standards or communitarian constraints regarding what is, and is not, permissible for individual contract relationships. One other fundamental principle that the community requires for its basic contract is a principle of honesty. Unfortunately, Veatch acknowledges (yet again) that the acceptance of such a principle may already have to exist before individuals can trust the promises made in the original contract.[57]

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[55] Veatch, p. 196-197.

[56] Veatch, p. 198.

Honesty is required in the physician-patient relationship for reasons involving disclosure and informed consent. Without a fundamental principle of honesty, patients could not believe their physicians and, thus, may not be confident in their subsequent decisions. As well, physicians could not be confident in the appropriateness of treatment if their patients do not also have an equal obligation to be honest. On the other-hand, if the physician must always be honest, then he/she may unduly upset his/her patients who would rather not be informed of all the particular details of their ailments. Accordingly, "at the level of the individual contract or covenant between lay person and professional, special agreements exempting one party from open, honest, or ordinary disclosure to the other seem acceptable."[58] This may be problematic for Veatch since it suggests that there are exceptions to the over-arching principles that are to govern all relationships within the three levels of contract. One way to resolve this is to argue that the principles are not absolute, but this would weaken their authority. For Veatch, the basic principles are very general and the patient's rights are very broad. Accordingly, when discussing the right to information, Veatch comments:

> Within the limit of the first two contracts, individual professionals and lay persons should develop a clear understanding of (the) right to access in their particular relationship. Will it include a right to the actual documents or only the information?...Will it cover information that physicians sincerely believe will not be in

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[57] Veatch, p. 215.

[58] Veatch, p. 219.

> the patient's interest to know? Some of these questions will probably be answered in the first two contracts, but a range of discretion is likely to remain.[59]

It is difficult to assess exactly how much discretionary power the individuals would have under Veatch's account. Although the freedom of the individuals to set the terms of the relationship must fall within the guidelines of the broader two contracts, such discretion could place the patient in an arbitrary or weaker position when dealing with one physician over another. One must be careful for otherwise this freedom may lead to renewed charges of individualism. Alternatively, one could suggest that there be a lexical ordering of the principles so that one may violate the principle of honesty for a higher good, thereby avoiding an ad hoc approach.

Perhaps the most controversial principle that Veatch includes as part of the social contract is that of "avoid killing". Veatch believes that killing is incompatible with the duties of the health care provider. He is concerned about the possible abuse of physicians being allowed to kill and as such, the taking of life is considered a "wrong-making characteristic".[60] In order to justify this principle's inclusion, Veatch adds to the controversy by adopting the non-consequentialist view that life is sacred.[61] Yet, whether rational people would, in fact, agree to this principle remains questionable. Perhaps aware of this, Veatch adopts an almost apologetic tone when he writes:

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[59] Veatch, p. 136.

[60] Veatch, p. 227.

[61] Veatch, p. 232-233.

> When I put myself in the position of one attempting to invent the moral rules for the community...I find that the prohibition on killing is one that I must cling to. It is morally an ultimate, and, therefore, no reason can be given for the conclusion any more than one can give reasons for choosing the principles of beneficence, liberty, veracity, or contract keeping...(nevertheless) the full force of my own conclusion is unacceptable to most people.[62]

Veatch is so strongly opposed to killing (and in particular "active killing") that he states that people who believe killing in a particular case is merciful, must justify that act as being an act of civil disobedience.[63] However, if it is admitted that most people would find this proposed component of the basic contract unacceptable, then it must also be admitted that a stronger defense of the claim must be put forward in order to persuade the public. This is a glaring exception to Veatch's general reliance upon the community for establishing the other principles that are to be adopted.

Being aware of the serious difficulties with maintaining a broad prohibition against the taking of *any life*, Veatch quickly refines his position so that he is speaking only about prohibiting the taking of life of those who have "the embodied capacity for consciousness or social interaction". Since fetuses in the early stages of development fail to possess Veatch's criteria for moral standing,[64] the performance of abortion, although it "may be a tragedy, it is not a moral violation".[65] The issue of abortion is a prime example of how, on the third level of contract, the individual physician and patient have the freedom to conscientiously disagree with the fundamental contract or with the professional group-society contract. However, were abortion a "moral violation", then no such freedom would be permitted.

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[62] Veatch, p. 233.

[63] Veatch, p. 237-239.

[64] Whether fetuses fail to possess the capacity for consciousness is controversial. Even so, just because a person has the capacity for X does not mean that they also automatically possess the rights associated with those capacities.

Veatch's final principle is one that is intended to resolve the problem between individualism and the social concerns over promoting the welfare of the aggregate.[66] This principle is the principle of just distribution of medical and economic resources. This pragmatic principle seeks to give people "net welfare equal insofar as possible to that of other people."[67] Voluntarily assuming health risks other than those that are for the public good results in Veatch's society making adjustments in how health care costs and distributions are determined.[68] For example, although both smoking and rescuing a person from a burning building are dangerous activities the former may not deserve public subsidy.[69] Yet, writes Veatch, a compassionate society will take into consideration the individual's autonomous choices which may reasonably considered detrimental and shift the economic burden of this sort of behaviour to a general health fee (or a general taxation on say tobacco products or alcohol). To do so is to:

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[65] Veatch, p. 247. Some may object to the inclusion of "tragedy" in this conclusion by pointing out that personhood seems to be an "all or nothing" state of affairs. Accordingly, on this view then, abortions should be views either as moral violations and hence as tragic, or not.

[66] Veatch, Chap. 11.

[67] Veatch, p. 278.

[68] Veatch, pp. 276-278

[69] Veatch, pp. 276-281.

> ...move beyond the individual without falling victim to the indiscriminate social benefits perspective. Striving to provide opportunities for health care to bring people insofar as possible to the health level of others allows certain social concerns into medicine without opening the door so wide that the entire societal wants list swamps the rights and welfare of the individual.[70]

In balancing of individual needs with the needs of the community, the principle of justice creates the role-specific duty of the professional to benefit the worst off and to treat his/her patients first except in extreme cases where the person on the street requires immediate medical attention.

Having sketched out Veatch's extensive tripartite response to the anti-contractualists I can now mention some of its difficulties. First, with all of the fundamental principles in place, there arises the standard problem of how to resolve any potential (or real) conflicts between them. A good ethical theory must have consistent statements. Given that pluralistic theories are difficult to maintain because of potential conflict, Veatch's own defense faces an uphill battle. Veatch considers a few possible solutions to resolve the possibility of conflict, none of which he believes "is terribly attractive."[71] He considers and then rejects a single over-arching principle of utility and then hastily concludes from this that no single, over-arching principle theory is plausible.[72] Although he dismisses the adoption of a lexical ordering of the basic principles on the grounds that individual cases differ and, as such, one principle may be more relevant in one particular situation and not in another, Veatch also maintains that the consequentialist principle of beneficence ought to be placed on a lower rung than all the other non-consequentialist principles. This latter claim is inconsistent with the previous position and is peculiar given that the pragmatic principle of justice rejects putting the costs of risky behaviour on those who voluntarily assume such behaviour, in favour of a compassionate model whereby such individuals are not excluded from equal health care opportunities. Apparently, all we can do to resolve this issue of balancing principles is to return to the original contract and see how "reasonable lay persons and professionals coming together would balance the (non-consequentialist) principles..."[73]

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[70] Veatch, p. 287.
[71] Veatch, p. 296.
[72] Veatch, pp. 296-298.

The above comments point to how Veatch continues to be imprecise with the finer points of his position. Unfortunately, it is these finer points that the reader requires to be informed about before they can buy into the theory. Another difficulty surrounds the establishment of the philosophical legitimacy of the social contract and the principles that are to be chosen by the rational self-interested agents. He writes:

> Unfortunately, not all agree that a universal basis is discoverable, is existing objectively for us to find by revelation, awareness of the natural law, reason, or our moral senses. This does not mean that an endless relativism is the only alternative, however. We may be able to bring many of the doubters into a common community of moral discourse. They may be persuaded that it is possible to invent a universal base, or at least a base large enough to accommodate everyone involved in medical ethical decisions. If the base they invent is identical with the one purportedly discovered by others, or at least largely compatible with it, then the two groups may share enough of a moral

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[73] Veatch, p. 304.

> framework to make common discourse and medical ethical evaluation possible.[74]

Practically speaking, this methodology might work. Yet, basing a complex theory upon assumptions that may or may not be true seems an artificial and intellectually unsatisfactory compromise especially given the controversial nature of some of the principles. It is for this reason that we ourselves have set aside the issue of universality versus the 'situatedness' of morality.[75] Furthermore, many questions continue to remain unanswered. "How do the agents initially decide to co-operate?", "Doesn't the contract already have to be in place in order for agents to follow it?", "How does the contract get generated?" "How can a fictional event have real force?", "What about the interests of individuals who are not rational and are not part of the original agreement?" Without answers, these questions remain stumbling blocks for most, if not all, social contract theories. Accordingly, with these weakness, one has to ask whether Veatch's approach creates more uncertainties and questions for contractarians.

Of those concerns that might be specifically related to the contractual element of Veatch's proposal, we have already acknowledged the relevant complaints against contracts. It has been argued that these general complaints can be accounted for when one has a better understanding about nature of contract theory. Accordingly, we need not go so far as to try and resolve the difficulties that some anti-contractarians raise by creating a social contract theory, since the charges are either misguided interpretations of contract law, or they fail to show the unsuitability of contractual influences in medical relations. Our approach is able to address or side-step those concerns that one unwittingly creates by proposing a new model such as Veatch's. The communitarian model that is presented in this dissertation is less "individualistic" than the classic liberal legal model and this should be of some relief to those who see the issue of individualism as being an inherent difficulty with "legalistic" contracts. Veatch, on the other hand, brings in different levels of contractual complexity to provide necessary relief. Unfortunately, part of the overall structure of Veatch's theory relies upon potentially conflicting principles that are ascertained more by intuition than by reason. Now, some of these difficulties may be such that with further management they can be resolved, or at least refined. However, it remains the case that the elements associated with covenants that Veatch wishes to protect can also be captured by communitarian ideals of trust, respect and support. As evidence of the further simplicity of the liberal communitarian prescription, the general rules that are to be set in place to govern the physician-patient relationship can be further examined to reveal specific applications that will manifest in different ways given the sorts of participants and situations that are involved, rather than having a hierarchy of governing levels. Even contract's detractors admit to the usefulness of a contractual approach to medical ethics[76] but there remains at least one major hurdle that any sort of contractarian position must overcome before the position can gain popularity and momentum.

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[74] Veatch, p. 117.

[75] See Chapter 1, Section III, p.9.

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[76] I refer again to the articles by Masters and May.

The major problem that faces the application of a prescriptive contract model to medical ethics is the simple fact that many patients are incompetent. On first blush, the notions of contract and incompetence are incompatible. Maintaining that incompetents can enter into contractual relations is problematic since entry into an enforceable contract requires that the agent has the intent to contract. Patients who are in a permanent vegetative state (PVS) surely do not have the capacity to form intentions. Yet, as there is some sort of relationship between physicians and PVS patients and between physicians and other sorts of incompetents, we are faced with the following quandary. Should we completely reject a pure contract theory because it cannot account for specific sorts of physician-patient relationships or should we opt for a theory that holds that the real contractual relation exists not with the physician and the incompetent patient but with the physician and some third party? If there are solid reasons to choose the former option, then obviously the contract hypothesis is seriously defective (if not fatally flawed). If we choose the latter option, then the notion of contract as applied to medical ethics becomes more complicated. Consequently, the theory's attractiveness is reduced since it affects the patient's right to equality within the context of contracting and does harm to the patient's rights. For instance, what would happen when the interests of the patient are different from those of the potential contractors? It is the legal recognition of contracts and the legal status of incompetence, combined with a communitarian interpretation that provides us with an available solution as well as a way to avoid the philosophical quagmire that Veatch finds himself in.

VI. Conclusion.

It has been shown that we do not necessarily have to step outside the legal tradition to answer Masters' and May's well placed concerns. The legal notion of contract will provide us with an opportunity to create a fundamental ethic to govern over the physician-patient relationship, while, at the same time, avoiding the fundamental difficulties associated with Veatch's many-principled social contract theory. In doing so, we will illuminate the useful and ethical ways in which physician and patient roles could function in the complex medical realm. Contract law theory provide us with the means to interpret and prescribe these sorts of relationships. However, contractual principles are not the only means of legal recourse that individuals currently have to resolve physician-patient conflicts. Agency of necessity, power of attorney and fiduciary obligations are all devices that fall outside the scope of our present examination. Whether these legal elements can act as appropriate legal templates upon medico-ethical situations remains to be discussed by others.[77] Suffice it to say however, the laws of the land often play catch up with the ethical values of the society. Some moral rules benefit from attached legal sanctions whereas in other cases, there ought not be any overlap between the two fields.

As stated above, the new proposal will be developed by offering a particular *interpretation* of the law of contract. Yet, before we can look at how this is to be done (and at what sorts of consequences this will have), we must first have a better understanding of the general workings of contract. This understanding will provide further justification for stating that the law of contract can handle its critics in an affective and efficient manner. Moreover, by looking at the essential components of contract, the problem of incompetency will become more identifiable. In time, we will also need to have an adequate account of incompetency before we can bring all these features together.

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[77] My thanks to Dale Gibson, Faculty of Law, University of Alberta, for pointing this out.

CHAPTER FIVE

The Meanings of Contract

I. Introduction

Given our rejoinders to the objections raised by Masters and May, we recognize that we do not need to move outside the realm of the law of contract to respond favorably to most of their criticisms regarding a contractual theory of medical ethics. We also argued that Veatch's social contract theory of medical ethics had limited success in bringing to our attention the need for external principles to govern the contractual relationship. Unfortunately, Veatch's response created a few difficulties of its own. In this chapter, we will see how legal contracts can be interpreted within the medical context and thereby attempt to avoid the problems associated with social contracts. One of the noteworthy consequences of this approach shall be the alleviation of anti-contractarian fears concerning the promotion of a physician-patient relationship that is too cold, calculating and unattached to the rest of society. We shall begin our exploration by first discussing the nature of contracts.

II. Interpretations

The justification for interpretation that this dissertation offers is parallel to the justification that can be offered for literary, art and film criticism. That

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THESES CANADIENNES PROVIDER-PATIENT CONTRACT 2 of 3 is, we will present a normative evaluation of how the law can be or ought to be viewed. Law-makers may not see the liberal communitarian reading as being appropriate, yet this approach can still be justified in that we are not intending to provide a descriptive evaluation of the law of contract. That I perceive certain themes in various books or films does not entail that the creators of those works cannot retort that such themes were not intended. One may consider Stanley Kubrick's film **2001: A Space Odyssey** as a metaphysical tale about life and death and the cosmos, whereas another may consider it pure entertainment and nothing more. However, it is more likely the case that the person who regards the film as just being about a computer gone crazy is simply engaged in offering a descriptive exposition of what appears on the screen, while the individual who "looks behind and beyond the screen" looks for deeper understanding and appreciation. One way this deeper understanding occurs is by trying to detach the metaphors from the medium whether it is the screen, the page, the stage or the letter of the law. In doing so, the work becomes more complex, more interesting and even perhaps more important regardless of the conscious intentions of the authors (or, in our case, the lawmakers).

Justification of the interpretative process does not depend upon determining what the intentions of the authors were during the creative process. That the director does not perceive his work as having certain meanings will not affect the significance of the critical analysis of his product. Instead, the meaning stems from the viewer's or reader's contact with the work guided by the rules set out by the relevant institution. Similarly, one may strictly analyze the letter of the law and one may also offer an assessment of the significance of the law from a more theoretical point of view. This theoretical point of view may not be in agreement with the intentions or the perceptions of the lawmakers. Accordingly, even if the descriptive text remains the same, the meaning that it has can alter depending upon the contextual perceptions of the interpreter. Hence, the meaning of the text is dependent upon the interpretation one gives it[1]. Stanley Fish writes: "It is not that we first read the statute and then know its purpose; we know the purpose first, and only then can the statute be read." [2]

Nevertheless, while it can be said that one is free to offer any interpretative claim on such matters, certain institutional guidelines or norms must prevail for no matter which position, theory or school of thought we operate from, we are always operating from some particular vantage point and these vantage points have structures whether Socialist, Marxist, Liberal and so forth. Regardless of whether the institution is literary study or philosophy, there are universally applicable guidelines that must be adhered to. These guidelines include such things as the necessity for the interpretation to be internally consistent, that there is evidential support for the premises, that the assumptions are not unreasonable, that the textual justification is relatively complete and not piecemeal, and finally, if there is counter-evidence against the interpretation then this evidence must be outweighed according to the rules of conductive argumentation. Thus, although one may be right to claim that almost anything goes in terms of interpretation one should not maintain that all interpretations are equally valid. Some interpretations are so misguided as to render them not only improper and misconceived, but just plain wrong. For example, we could not say that the film **2001** is an allegory about the rise of the Microsoft corporation, for the film pre-dates its incorporation. However, seeing the film in more general terms as, for example, an allegory about the significance and dangers of technology would not be unreasonable. Fish offers an example of how interpretations can be less than satisfying although still argued for:

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[1] Stanley Fish writes: "(S)ince language is only encountered in contexts and never in the abstract, it always has a shape, although it is not always the same one." **Is There a Text in this Class?** (Cambridge: Harvard University Press, 1980) p. 268.

[2] Stanley Fish, *p. 268.*

> For some present-day readers Christ is 'in the text' of Samson Agonistes, for others he is not...(I)t is important to see that the question of what is in the text cannot be settled by appealing to the evidence since the evidence will have become available only because some determination of what is in the text has already been made. (Otherwise it would be impossible to read.) Indeed the same piece of evidence will not be the same when it is cited in support of differing determinations of what is in he text. Thus, for one reader the fact that Christ is not mentioned 'proves' that he is not in the text, while for another the same 'fact' (really not the same) proves that he is.[3]

The parameters of interpretation are elastic and malleable and they may be stretched considerably. However, if the concepts are stretched too far then they are apt to snap and lose their significance and usefulness.

What follows is the first part of the interpretation process, an exposition and presentation of the contents of contract law as applied in the courts.[4]

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[3] Stanley Fish, p. 274.

[4] The genus of the material that follows is drawn from a variety of legal tomes including, G.H.L.Fridman, **The Law of Contact in Canada** (1986), Thomas Dunfee and Frank Gibson, **Legal Aspects of Government Regulation of Business** (1984).

Using this exposition, we will see first, how the legal model fits with the physician-patient relationship and second, how the law of contract can, upon reflection, support (perhaps unintentionally) the ideals that are consistent with a liberal communitarian interpretation. Whether this work stretches the interpretation of contract too far is left up to the reader.

III. What Contracts Are.

Contracts are legally recognized agreements that give rise to certain judicially enforceable obligations. Contractual obligations are voluntarily assumed in that they derive from agreements which individuals are free to make or refrain from making.

The essential elements that make up contracts are consideration, offer and acceptance. Consideration entails that there is a creation of some benefit to the party promising or some inconvenience to the party to whom the promise is made. Mutual promises are consideration for each other as both parties have something to gain and lose. Accordingly, the consideration doctrine is aimed at fairness to ensure that the agreement reached involves the exchange of something for something else (e.g., the exchange of ten dollars for a new hat.)

Adequacy of consideration is not considered because under the *laissez-faire* policy, courts do not test to see whether the economic value received by both parties is roughly comparable (e.g. Is the item worth X dollars?)

Instead, the courts are only concerned with the sufficiency of consideration in the sense that both sides incur a bargained-for legal detriment. Whether the parties involved make a good or bad bargain is not important given the breadth of the freedom of contract.

An offer is a statement to the effect that the person is willing to contract on the terms stated. Offers can be stated or done by conduct. For example, I may see a nice hat in your store on sale for ten dollars. If I take the hat to the counter and remove ten dollars from my wallet and present both to the sales clerk and exclaim "I'll take it!", this conduct can be rightly seen as an offer to purchase. Contractual offers must manifest contractual intent; it must be definite and certain regarding the essential terms of performance and of the proposed contract. Moreover, it must be communicated. The first of these criteria, intent, must be objectively determined by the "reasonable persons" test whereby the words and actions of the party in question are to be assessed. My remarking: "That's a nice looking hat and so reasonably priced too!" does not entail an offer to contract. The storeowner's acceptance of an offer must be unconditional. Acceptance must mirror the offer and it must be communicated. When an offer is accepted then there is a contract. Accordingly, a purported acceptance that introduces different terms into the agreement is not an acceptance but, rather, a counter-offer (and hence, there is no contract). Withdrawal and notification before the offer is accepted, rejection of the offer, time lapse, occurrence of condition, death or incapacity are all permissible forms of termination of offer.

Sometimes there is not an identifiable offer and acceptance, yet there is a contract. In some cases, there is a contract but the process of agreement cannot be analyzed in stages of offer and acceptance as it may not be clear who made the offer and who accepted. For example, persons who have entered the emergency room seemingly are not engaged in a direct contractual relationship since they cannot be said to be involved in offering and accepting the terms of the deal. This, you will recall, is one of the presumed counter-examples to the acceptability of applying contract theory to medical relationships. Nevertheless, we can portray the emergency room physician as having a multi-party contract that entails that the unconscious patient who is in need of medical attention is to be treated when necessary, unless the physician is otherwise informed[5], or until the individual regains consciousness and informs the physician of his/her acceptance or rejection of the offer. With the multi-party contract, one party contracts with another to provide services for the benefit of a third party. Accordingly, if physicians have contracts with the institution where they practice, and the institution has a contract with the community to treat its members, then we have satisfied our stated requirments. As well, a person's entering the emergency room of the hospital constitutes an unstated agreement to be administered to unless otherwise indicated. Furthermore, emergency treatment without the consent of the patient can be presented as being representative of a unilateral contract in some cases where consent by the other party is not required and where a second physician's signature on the consent form signifies the patient's interests as being represented by a third party.

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[5] For example, the patient may have an advance directive card on their person that rejects various forms of treatment.

To support this view of a contract existing in the emergency setting, we note firstly that some physicians (i.e., hospital residents) can be considered employees by hospitals which are under contract to provide services to any member of the community who may enter and require medical treatment. The agreement between the individual parties (or their representatives) are promises which bind one to one's future conduct to either pay for the service, administer the service, or sincerely follow the recommendations in exchange for the promise of trustworthy treatment.[6] The patient's promises of fee payment may be the direct responsibility of the patient or it may be indirectly garnered from the community through taxation or health care insurance. Thus, practicing physicians have a contract with various representatives of society to provide services in exchange for fees paid. If the physicians accept the offer to treat patients in exchange for financial compensation, they must provide their services. Accordingly, when individuals enter the emergency room the physician is *prima facie* obligated to treat them. However, if the physician refuses the offer because it conflicts with his/her personal convictions, and he/she does not treat the patient, then there is no contract established.

Whether the unconscious person who was admitted to the emergency ward did not expressly communicate the terms of agreement, or whether the person walks into the general practitioner's office on his/her own volition, we can see medical contracts existing within the parameters of essential elements of legal contracts and not social ones. The contract between the individual parties, be they patients, physicians or the community, all contain elements of consideration, offer, and acceptance.

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[6] Instead of promises, the purer representation of this agreement might be the barter system whereby patients gave doctors some item or service in return --which was common in the past where farmers would exchange goods for medical treatment.

This general interpretation of contract, when combined with the suggestion that the community is often the trainer, provider, employer and third party payer of the physician's services, goes a fair distance to provide one solution to the issue of requiring different types of physician-patient relationships depending upon the particular circumstances. It also avoids Veatch's problem of having to establish the philosophical legitimacy of the social contract and the principles that are to be decided upon by the rational self-interested agents. Questions such as: "How do the agents initially decide to cooperate?", "How does the contract get generated?", "What about the interests of individuals who are not rational and, hence, are not part of the original agreement?", are all common difficulties associated with social contract theories. But there is no need at this point to debate whether rational persons would really choose the principles that Veatch says they would. As well, we do not have to debate the philosophical merit behind the social contract account because the physician activities including training and education, experimentation upon volunteers and service fee recovery all imply that some sort of agreement has already been implicitly or explicitly established within the community.

Although a specific agreement between two parties may determine that there is a contract, it does not necessarily determine all of the contents of the contract or its scope (i.e., "the terms of the deal"). For example, there may be terms which are implied in the contract which need to be taken into account and which may actually impose duties upon the contracting parties. The vendor implicitly undertakes the obligation to provide merchantable goods and the physician undertakes the duty to provide reasonable care. However, what if the party fails to uphold their end of the bargain?

The law of contract asks the following sorts of questions: "Has an agreement been reached between the parties involved?"; "Is this agreement one which should be legally recognized?"; "What remedies are there if the contract is broken?" This last question has the potential to be the most important one because if the contract is broken without remedy or protection, then, generally speaking, inter-personal cooperative transactions cannot continue. The reason that this is the case is because if there were no repercussions when contracts were broken, then the notion of a contract would lose its force. Just as someone might act in a morally right way because they fear being caught, persons may hold to their contractual obligations because of the fear of sanctions. It would be nice if people would keep promises out of a sense of duty, however, some may not want to hold to their promises if they know that there is no penalty for failing to keep them. Without the fear of repercussions, there would be loss of expectation, efficiency, stability and predictability -- all of which would jeopardize the continuation of future cooperative ventures between individuals. Physicians, patients, lawyers, clients, shopkeepers and customers must all be held accountable for their actions and be rewarded or punished accordingly. Clearly, this is an agreeable position since we would consider the physician who receives funds for services that were not rendered to be unjust, and the patient who never keeps his appointments or misleads the physician would be considered to be abusing their health care privileges.

Continuing along this line of reasoning, if I give you monies in exchange for some item or service and you fail to provide me with that item or service then you have broken the contract and I deserve restitution. In contracting, each party has restitution interests, reliance interests and expectation interests. Restitution is invoked in order to put the complainant in the position that they would have been in had the contract not been made. When I give you ten dollars for a hat and you fail to give the hat to me, restitution requires that you return my ten dollars.

If I have agreed to contract with you and I have incurred various expenses or losses in relying upon the contract, then, when you fail to uphold your obligations, I am at a disadvantage. Thus, if you break the contract I may deserve reimbursement for those losses. As well, I may also deserve some compensation because my expectations that arose out of the contract have been disappointed by your failure. For example, if I order a product from you and I don't receive it, then I also fail to receive the profitable use of it. I can sue you for damages in respect of the product cost and the profit loss. If my physician performs the wrong procedure or performs it incompetently, then he/she has failed to provide me with competent services for which he/she is typically reimbursed on a fee for service basis. I might then sue for restitution of any relevant fees that were charged and may deserve compensation for any physical and emotional harm done.

If the party who failed to carry out his/her part of the contract could not be expected to carry out the contract, he/she is not in breach of contract. It is frustration of contract, not breach of contract, when the physician, who is on the way to the hospital to perform surgery, is injured and cannot fulfill his/her part of the contract. As well, if action that both the patient and physician agreed to was illegal (such as active euthanasia), and the physician changed his/her mind about performing the task, the patient could not sue the physician for non-performance, since illegal agreements are not enforceable.

Interpreting the physician-patient relationship as a contract relationship does not necessarily force one to adopt an anarchistic "individualistic" view of that relationship -- a relationship where there are no governing moral rules. Even within the traditional model, there are various safeguards in place to protect both parties, albeit at a minimal level, which act to counter various abuses that can occur within the freedom of contract. As we discussed in the previous chapter, because we are not all on the same playing field in terms of knowledge, skill, power, authority and resources, various measures are put in place to protect those who are in the disadvantaged position either by protecting them from being taken advantage of or by protecting them from acting in ways that are not in their best interests. Indeed, simply being in a disadvantaged socio-economic position can affect one's freedom to contract because of the associated lack of resources and, as such, the liberty to contract can be a hollow victory for those individuals. It is a simple truth that if a person is wealthy, then they are at liberty to be much more selective in their buying and bargaining than those who are poor.

In order to combat the atmosphere of tyranny that unlimited freedoms can foster in favour of the stronger parties, we have established various rules and parameters including such things as child labor laws and minimum wage laws to provide a basic living. Even the requirement of companies to label their products helps the buyer be aware of what they are purchasing rather than simply relying on the goodness of the producer to reveal pertinent information. All of these actions have been challenged by libertarians as being too restrictive upon the important principle of autonomy and free enterprise. Nevertheless, the merits or demerits of these interferences with the freedom to contract point to a community interest that places some importance on the value of fairness of contractual processes even at the cost of supplanting the freedom of some.

The safeguard of disclosure also reflects the presence of various constraints upon the liberty of persons to contract. In most contracts, there is no duty to disclose beyond the minimal assumptions that the products are safe. Yet, there are exceptions to the rule. Interactions involving purchasing insurance and medical treatments demand disclosure by custom. Duty of disclosure is clearly of extreme importance in *Uberrimae Fidei* contracts whereby one party is in a much better position to know the material (and often complex) facts.[7] As such, statutory duty of disclosure is designed to protect classes of persons such as investors, consumers and patients. In a medical context, we can see the need for this disclosure as the physician enters the relationship in a powerful position, having vastly greater medical knowledge, expertise and resources at hand regarding the various ailments, diseases, treatments, risks and prognoses than the typical patient. The duty of disclosure (or lack thereof) is relevant in the hospital or office setting where patients are asked: "Do you understand what I have told you?" Unless the patient truly understands and appreciates the medical information including the procedure, inherent risks, realistic alternatives, options and outcomes, then the patient cannot make an informed choice regarding whether to exercise his/her right to accept or refuse medical treatment. Accordingly, the duty is more than just informing the patient, but rather, informing the patient in such a way that he/she (or the guardian) understands what he/she is being told.

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[7] *Uberrimae fidei* translates as: "Of the fullest confidence" or "Of the utmost good faith". "A contract is said to be *uberrimae fidei* when the promise is bound to communicate to the promisor

Some physicians perceive the duty of disclosure as onerous since "full disclosure" is practically impossible. However, once it is determined that disclosure is needed in order for the patient to make an informed decision, full disclosure may be unnecessary. Instead, the duty to disclose entails a duty of "reasonable disclosure". In order to decide how to most efficiently achieve his/her goal, the patient does not need to know the name of every single instrument to be used, nor does the patient need to know the fact that there is always the remote possibility of earthquakes

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every fact and circumstances which may influence him in deciding to enter into the contract or not. Contracts of insurance of every kind are of this class. To a certain extent contracts for the sale of land, for family settlements, for the allotment of shares in companies, and contracts of suretyship and partnership, are also within this principle. Taken from: **Osborn's Concise Law Dictionary**, 7th ed. (London: Sweet & Maxwell, 1983) p. 332.

or civil uprising that may interrupt the operation. This sort of disclosure would scare off anyone from agreeing to the procedure. To achieve one's subjective interest --which, in most medical cases, is to achieve some level of physical amieloriation,[8] relevant information needs to provide answers to such questions as whether the procedure is required, whether it will hurt, how long the recovery will be, if there are side effects, if there are alternatives and so forth. The level to which disclosure is given is dependent upon the interests of the patient to be informed as well as the requirement of the physician to ensure that the patient understands what they are consenting to. A young patient may be made more apprehensive if the physician discloses too much information, while, on the other hand, if the child's physician and parents remain secretive, the minor may become fearful of the unknown.[9] Some patients may request not to be informed of all the details but rather they may just request the most basic information. In such cases, one must be careful that the patient doesn't place too much blind trust in the physician who, although genuinely interested in the patient's well-being, may permit personal values to override and influence his/her professional judgment.[10]

If we cast a negative light upon those physicians who believe that even competent patients are not in the position to have a good understanding of the situation, then we should also be concerned about competent patients who voluntarily transfer their right and responsibility to make an informed decision into the hands of the (perhaps unwilling) physician. Such patients may be understandably motivated to hand over control on the grounds that believe they lack the ability to make a proper decision or because they believe that "whatever the doctor says must be true for they know best". While the patient may feel more at ease or more confident in allowing the physician to decide for him/her, we have to wonder if it is simply a matter of the patient wishing to avoid making hard decisions. Accordingly, he/she may be placing too great a burden on the physician who can (and should) refuse to accept this onerous task.

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[8] I say 'most' since physical betterment may not be possible in some cases. However such patients may be assisted in terms of emotional and spiritual healing. Whether this extends the notion of 'health' too far (and thus the concept 'snaps' back at us) is of great debate. See for example, Daniel Callahan, "The WHO Definition of Health", *The Hastings Center Studies*, 1:3 (1973) pp.6-15.

[9] This is assuming that the child in question is competent and capable of being informed. While some children may not completely understand what is going to happen to them, it is useful to try and involve the child in as much of the general decision making process as possible in order to ease their fears. See Chapter 7 for further discussion.

[10] It is here that some degree of collegial familiarity with the patient would be most useful.

Undue influence is applicable when the relationship between parties is such that one of the parties is in a position to take unfair advantage of the other. Relationships such as parent/child, doctor/patient, solicitor/client, are all prone to undue influence concerns. This potential problem is found in those relationships where there is trust and confidence between unequal partners. In such relationships, there is always an assumption of undue influence and it is up to the person in whom confidence is given to refute the presumption. This is done by showing that the other party has been independently and competently advised before entering the contract. Charges of undue influence may take the form of improper pressure or duress. For example, physicians may use overly technical or emotionally loaded language in a coercive manner in order to promote or discourage a particular method of treatment. If one of these conditions arises, it may result in the contract relationship being voidable. Along these lines, if there is imbalance of bargaining power, then there may be relief from harsh bargains on the grounds of inequality. However, given that contract obligations are voluntarily assumed in that they derive from agreements which individuals are free to make or refrain from, inequities of consideration may not be rectified. Relief against harsh bargains on the grounds of inequality of bargaining power is seen by some as a vague method of resolution. The expansion of the concept of duress may reduce the need for such an approach. Of course, any financial rectification is going to be seen as being unable to satisfy cases that involve physical harm or death since it would be better if the harm or death did not occur in the first place. Financial compensation does not always restore things to the way they were.

Against the "wide-open" notion of freedom of contract in medicine and in favour of the need for constraining rules regarding undue influence, we point to the advances of medical technology which makes it even harder for the average patient to gain any substantial knowledge about his/her medical treatment. The complexities of modern medicine widen the gap between the positions of the physician and the patient so that with each new advance there is a greater potential detriment to the establishment of equity between the two individuals. Accordingly, with the seriousness of such situations, there is even more impetus to make sure that the patient is provided the opportunity to make a reasoned decision.

Another means of contractual rectification concerns the issue of misrepresentation of the facts. Misrepresentation of what the contract entails places the individual in an unfair and advantageous position as he/she is bargaining with an unsuspecting party who may not have agreed to the terms of the contract had he/she been informed of the truth. However, if a person utters what he/she believes is true and it is both reasonable for him/her to believe that information, and the person has special knowledge or skill in the matter then the statement may be taken as a fact. Such is the case when a physician states his/her professional opinion regarding some medical treatment.[11] A statement of belief contains a representation that the person uttering the statement actually holds to the belief and holds it on reasonable grounds. If the physician does not want to upset his/her patient and states that the risks of a procedure are minimal when he/she really believes that the risks are life-threatening, then there is misrepresentation. When there is misrepresentation, there are grounds for taking action against the physician if the patient is harmed or would have chosen not to consent to the procedure had he/she been informed.

IV. Subjective Considerations and the Intent to Contract

In the previous section, we dealt with what is called the *objective* determination of contract fairness. Here, we will discuss the *subjective* determination of contract fairness. Even if consideration and agreement are obtained without a violation of any of the above concerns and there is no breach, frustration or illegality of performance, if there is no contractual intention then there is no contract. Some incompetent patients (e.g., the severely brain-damaged) do not possess the capacity to form intentions and, thus, it would suggest that they cannot form the intent to contract. As such, physicians cannot contract with the severely incompetent, but instead other agreements and other parties must be brought into the equation. This aspect forms the core of the new medical ethic as it relates to the principles of autonomy and beneficence. While we shall reserve the resolution of this topic until we engage in a discussion of what counts as competency, we can, at this time, point out the current ways that the courts decide which persons may form contract.

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[11] Even here one must be careful that the physician is knowledgeable in the particular area of medicine that he/she is discussing with his/her patient.

In terms of who may contract or, more specifically, who is liable under the terms of the contract, the legal immunity that minors (i.e., persons under the age of eighteen) possess has led to the introduction of methods by which the other contracting party can also be protected. For example, parties contracting with minors seek out the involvement of a third party, namely, an adult guarantor of the contractual agreement. The purpose of regulating the rules of contract for those under the age of eighteen is to protect them from their inexperience. In other words, regulations provide a safety net for those individuals who may otherwise find themselves in unnecessary, burdensome and otherwise unfair contracts. For example, if one of the parties is a minor, then one sort of contract that is void is the repayment of monies for goods that are not necessaries.[12] Employment and other analogous contracts are endorsable subject to conditions or provisions stipulated by legislation. Minors are bound by a contract of employment so long as it is on the whole for their benefit and is in no way derogatory to their position.

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[12] Necessaries are goods suitable to the condition of a person's life and to his actual requirements at the time of sale and delivery. A house may be necessary to a married minor but for the unmarried minor it may be a luxury. However, minors are liable to pay for those necessaries that they have purchased and which have been delivered.

Hence, there is precedence for establishing limited contracts with those considered incompetent. However, there is an equivocation here since the incompetency of minors is based on a legal notion and not a medical one. That one is competent to enter a contract can depend upon whether or not one is considered a minor regardless of whether or not one is mentally competent. The claim that one is incompetent solely on the grounds of one's age makes the discrimination against that individual readily evident. In some cases, this discrimination is justified.[13] Yet, the deciding factor of whether a person is capable of giving consent to a medical procedure should be based upon whether or not one is mentally competent to do so and not upon an arbitrary age limit established by the law. Otherwise, this restriction would deny persons who are clearly able to act according to their own interest, the ability to exercise their autonomy to do so.

Whether all minors are inherently incapable of understanding the nature and effect of the contract is questionable, since their understanding is more likely related to a combination of factors including their mental age, the complexity of the situation and the seriousness of the risks involved. Many children exhibit signs of forming intentions for very basic agreements: John agrees to trade his peanut butter cookie for Jane's apple; Michael promises to clean up his room in exchange for going to the movies on the weekend. Nevertheless, the complexity of contracts may require a minimum age being assigned as a matter of practicality and is justifiable as the court's interest lies with the individual's recognizing the impact of the contract upon his/her way of life. Trading cookies in a playground has far less impact on a child's future then agreeing to work long hours after school.

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[13] Commercial contracts may rightly require age constraints due to the enormous risks that contracting parties would assume if they relied upon minors to meet their financial responsibilities.

The defense of incapacity can succeed where defense of unconscionability fails because incapacity does not require that the contract be unfair. Instead, if an individual is deemed incompetent and cannot enter contracts, the contract is voidable. The person who has been judicially determined to be insane and, hence, incompetent may lack both contractual capacity as well as contractual authority since the state may take over his/her estate. In either case, the insane cannot give contractual consent. A contract is subject to being voidable if one party is mentally incapable of understanding its nature and effect *and* this incapacity is known to the other party *or* the contract is objectively unfair.

Accordingly, whether one is incompetent because one is a minor, or one is competent but unduly placed in a disadvantaged position, there are contractual constraints that are enforced by the state. Thus, it is the case that the *laissez-faire* model is not as "open-ended" as some have suggested (as we've seen) since there are state remedies in place to govern, regulate and limit contractual relationships of all kinds. Some of these policies are aimed at protecting the vulnerable, while others are aimed at providing relief against harsh bargains. Still, other policies are aimed at protecting individuals from those who are at risk of not being able to uphold their contractual duties. Nevertheless, the traditional contract model seems best suited to two parties voluntarily entering into a relationship that will give various rights and obligations to each. However, it is not clear that the physician-patient relationship is simply a one-to-one relationship within a universal health care system since third party interests (i.e., the interests of the community) will need to be acknowledged. As well, there remains the issue of dealing satisfactorily with the interests of incompetent patients who are also governed under the same social rules.

An individual is not a totally independent entity disconnected from the society in which he or she lives. Neither, however is the individual a mere cog in an impersonal machine in which his or her values, goals and aspirations are subordinated to those of the collectivity. The individual is a bit of both.
- Justice Wilson in *R. v Morgentaler*[1]

CHAPTER SIX

Collins, Contract and the Complexity of the Community

I. Introduction.

From the previous chapter we see that there are some constraints existing within the judicial system that prevent what we would consider to be unfair or immoral agreements occurring between two parties. Nevertheless, it remains the case that the key ideals of traditional or "classic" contract which include the "preservation of personal freedom, minimal regulation of market transactions and public control over the social order" provides ammunition for those who oppose a contractual theory of medical ethics.[2] The reason for this is that the principles of liberty, equality and reciprocity which legitimizes power relations in accordance with the classical rules of law[3] create situations where one party can dominate over another via "freedom of contract".[4] Such domination is unsatisfactory in physician-patient relationships. However, Hugh Collins in his book: **The Law of Contract**, offers us the view that the key ideals have progressively changed with the development of modern law. He argues that the 19th century liberal ideals of freedom of contract are being transformed to the social values of "fairness, trust and cooperation".[5] With this development, modern law of contract ultimately aims towards ensuring that "parties with weaker bargaining power, lesser expertise and no special knowledge are not exploited or put upon".[6] Although Collins' position is not to be considered mainstream and he is not addressing the issue of health care, his portrayal of contract accurately captures the sort of situation that patients often find themselves in. Patients in physician-patient relationships often find themselves faced with an imbalance of power since modern technology makes it harder for patients to know substantial information about their situation. This imbalance in turn leads to greater discrepancy in the positions of physicians and patients. Accordingly, there is more at stake now than there was a century or even a decade ago.

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[1] *Morgentaler, Smoling and Scott v. The Queen* (1988) 1 S.C.R. 30.

[2] Collins, Hugh **The Law of Contract** (London: Weidenfeld and Nicolson Ltd., 1986) p. IX.

[3] Collins, p. 9.

[4] Collins, p. 12.

In the process of trying to justify the reasonableness of a liberal communitarian theory of medical ethics, I wish to focus upon the philosophically interesting statement which is put forward in the preface of Collins work:

> At a deeper level this description of the law rests upon the jurisprudential perspective that legal reasoning comprises a species of practical reasoning inseparably intertwined with moral values and social policies. Like other kinds of practical reasoning, it is controversial, it cannot produce definitive answers to disputes by reference to authority, and its conclusions are constantly

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[5] Collins, p. IX

[6] Collins, p. IX

> challenged and restated in the light of experience and changing moral and political values.[7]

The changing political values that Collins is referring to are the same values that distinguish the Canadian Health Care system from the American system. In Canada, access to basic medical treatment is seen as a claim right, that is, one has the opportunity to acquire medical care and this right confers obligations on others to provide it. In the United States, access to medical treatment is seen more as a commodity that can be acquired by consumers who can afford it. In view of this distinction, it must be conceded that the *laissez-faire* theory of contract would be more easily mapped upon the consumer-driven market of the U.S. Moreover, the concerns and worries about minimalism and individualism are less of an issue in the U.S., although their worth should continue to be the topic of debate.

In this chapter, I shall give an account of the reasons that Collins puts forward for rejecting traditional contract. I shall then proceed to explicate and evaluate his thesis and reflect upon the implications of Collin's theory on our interpretation of the physician- patient relationship. All of this will be discussed within the liberal morality that has been at the foundation of traditional contract and in a general way, the Canadian political climate. As such, the "Canadian framework" will not be evaluated on its own merits.

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[7] Collins, p. X.

II. Playing Fair.

Given human nature and the existence of limited resources, the need for regulating behaviour is apparent. You and I may have a competing interest in possessing the same rare object and although one of us may acquire this object, the possibility of the object changing hands, either by renewed conflict or cooperation, does not cease. Some have offered that market transactions do not need legal enforcement -- offering that one can work without them. For example, Collins cites the case where the lack of legal sanctions on market transactions of the Trobriand Islanders seems not to result in conflict or chaos. Here, if an agent does not fulfill his/her part of the bargain then the other party merely acts reciprocally and does not fulfill his/hers. Yet, as Collins rightfully points out, what actually underlies the ordered behaviour cannot be a fear of legal reprisal since there are no legal avenues available.[8] That the fisherman does not give a portion of his catch to the farmer who did not give him fruit suggests that what could be occurring is that the parties involved are either following some general social norm governing interpersonal behaviour or are reacting instinctively. That is, either the parties know and abide by some sort of cooperative rule as set out by the community or that they all share common instincts. If it is a matter of instinct, then this particular discussion is best left up to the evolutionists, anthropologists and sociologists. If it is a social rule, then it is not clear whether the governing rule is promoting altruistic cooperation or cautious self-interest -- either of which can lead to the flourishing of the community. Of course, one could collapse the distinction between self-interest and cooperation as they do not have to be at odds with each other if we look at the end results of the rule-abiding behaviour. Hobbes forcefully argued that it is the rationally self-interested person who joins forces with other like-minded individuals to overcome the nasty, short and brutish existence of solitary life.[9] As such, the self-interested person may come to cooperate with the altruist.

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[8] Collins, p. 5.

Indeed, the reasons why one follows a certain rule may be as varied as the number of individuals in the community. I may obey the law because I fear punishment or social ridicule; I may obey the law because I respect the commandments of my elders; I may obey because of a divine command or because the laws are in agreement with my rational judgment, or my intuition. Yet, because some of us wander from these rules, there is the need for the legal reinforcement of our behaviour in market transactions. What is important in our society or in the Trobriand community is that there is some form of mutual agreement where persons abide by a set of rules and if the rules are violated, one duly submits to the sanctions. Unfortunately, the above case offered by Collins does not resolve all the possible contractual conflicts that could arise. Unlike the Trobriander Islanders where if one party doesn't keep his/her part of the bargain, then the other party simply doesn't keep his/her part either, there are situations in which the other party may have already fulfilled his/her part of the agreement. If I keep my part of the bargain and rely upon you doing the same and you fail to do so, I may not be able to rescind or stop the actions that I have already taken or put into motion. For example, I may have paid you in advance for your services that you then fail to carry them out. If you do not give me what I am owed, then I may rightfully seek out compensation by drawing upon some sort of legal sanction. As well, if these sorts of legal sanctions do exist, then in order for them to not be untethered, unstable and unpredictable rules blowing about by the winds of whoever is in power at the time then they must be grounded in general principles. Indeed, "one needs principles to give meaning and coherence to technical rules."[10] Veatch has offered us a wide variety of principles to govern, however, as it will be discussed in the later chapters, we will only require two: a limited sense of autonomy and a guarded sense of beneficence. These two principles will provide the framework necessary for a community-based governance of the provider-patient relationship.

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[9] Thomas Hobbes, **Leviathan**, *De Cive*, Ch. 13.

The traditional law of contract maintains that the purpose of legal regulation of contracts is to create a "facility to pursue voluntary choices".[11] The view being promoted here is that freedom of contract promotes the conception of individual responsibility. It follows then that voluntary contracts are necessarily fair and thus promote and protect autonomy.[12] The law enforces contracts even if the consequence is more burdensome on one party then originally believed as it is impossible to evaluate the obligations undertaken by both parties and have an objective calculation to determine when disproportion is unjustified.[13] More generally, the traditional view maintains that it is wrong to criticize or attempt to revamp this basic institution of market transaction regulations because any degree of infringement undermines individual autonomy and/or is inefficient.[14] The traditional ideal is that of a liberal state in which the law maximizes the liberty of the individual and "encourages self-reliance".[15] Yet, the further we move to promote individualism, the further we revert to a state where many have little if anything to rely upon. In this environment, persons become subject to the good will of those who are more capable and more powerful than themselves for no reason other than being positioned more favorably in the social hierarchy.

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[10] Collins, p. 8.
[11] Collins, p. 1.
[12] Collins, p. 139.
[13] Collins, pp. 138-141.

Collins argues against the traditional approach by claiming that it is communitarian and not individualistic (and possibly antagonistic) values that channel the market.[16] This communitarian ideal includes assisting the weak, distributing wealth fairly and promoting altruistic interests.[17] That a contract is made voluntarily does not make the agreement fair. To determine fairness, one needs to examine the bargaining power of the parties involved.[18],[19] Contrary to the traditional view that there is no objective criterion to determine value, Collins holds that one can develop a rational calculus "reflecting competing policy considerations".[20] These considerations are reflected in our setting standards for when a contract is acceptable. Accordingly, setting fair fee schedules for medical services can be done and, while challenging, they are representative of these considerations.

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[14] Collins, pp. 139-141.
[15] Collins, p. 1.
[16] Collins, p. 1.
[17] Collins, p. 1.
[18] Collins, p. 141.
[19] One need only recall our discussion of monopolies in the previous chapter to get a sense of this.
[20] Collins, p. 142.

Policy choices involve altruistic motives as typified by the law's requiring one party who injures another to pay compensation. Altruism allows for "excuse" whereas on the individualist scheme, the policy would be one in which it would be argued that the injured party should have looked out for himself/herself (i.e., "buyer *or patient* beware") and should have avoided binding himself/herself to obligations that he/she could not fulfill. Not to overstate the case, this latter policy seems like the promotion of legalized "thuggery" as it allows the weak to be victims of those who are in stronger positions. It is for this very reason that we grant certain rights to persons that cannot be violated by those who have the ability to do so.

To avoid harm to patients, patients must be competent to consent, reasonably informed and appreciate that which they are about to undertake. In this manner, the patient is protected from being taken advantage of. Traditional liberal contractarians who are against this sort of general interference are met with Collins' rhetorical question: "Is freedom to contract a fundamental constitutional principle?"[21] "No" is the response since "an uninhibited market is just one of many (possible) systems of distributive justice".[22] With a national health program that has physicians being reimbursed on a fee-for-service basis, there cannot be an absolute freedom to contract as the ethical and financial costs to the community would be astounding. The fee structure could be set arbitrarily high, or it could be set at different levels depending upon supply and demand. As well, different standards of treatments could be developed for different individuals who have the same affliction and so forth. Moreover, under this state of affairs, if the reimbursement structure remained intact, it would be reasonable to expect that third party payers would have the right to withhold funds for unreasonable requests.

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[21] Collins, p. 142.

[22] Collins, p. 142.

Regarding the suggestion that state interference serves only as a way to promote the inefficiency of contracts, Collins offers that inefficiency rates can be compared and balanced accordingly, (e.g., taxation versus contractual regulations and minimum wage laws versus taxation.)[23] Each case, he suggests, should be examined on its own merits as the social usefulness and efficiency of contracts need not be assumed to be best served by the *laissez-faire* approach. Still, we must not over-extend our altruistic interventions past rules governing basic rights, coercion, fraud and capacity to contract, since the more interference there is, the greater the possibility of the state's actions reducing the enforceability of contracts. At one extreme then, persons in weak positions may be unjustly treated while at the other, the stronger the state involvement, the greater the chance that those parties whose actions are curtailed will fear the instability of future transactions.

In Canada, the fears surrounding "freedom of contract" have been reduced in the name of promoting a principle in addition to that of individual freedom. Individual freedom is an integral aspect of justice but it remains just one part of the equation. Tobacco companies are not free to mislead consumers about the safety of their product, even though such restrictions limit their freedom of expression. The Supreme Court of Canada can and does sometimes rule that an individual's rights may be violated so long as that violation can be demonstrably justified in a free and democratic nation.[24] The priority of liberty has been reduced by a priority to protect those who rely upon others whether or not there is explicit consent.[25] Liberty by itself under freedom of contract is an empty gesture if it is not accompanied by some notion of fairness since many persons will fail to acquire any resemblance of status affording them the benefits of liberty.[26] Modern law, states Collins, is moving away from protection of individual freedom *carte blanche* to an "emphasis upon fairness in the distribution of wealth out of respect for the dignity of individuals."[27] Promoting an interpretation of liberty that allows others to cause harm to certain persons and which does not provide the means of resolution or restitution to the injured parties, should find little support from egoists or altruists. The reason for this is that there is always the possibility that the egoists and altruists will be the very same ones whose interests are being harmed.

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[23] Collins, p. 143.

Collins is motivated by the view that society is a collective. The role of law is seen as not only promoting transactions but regulating them as well so that the state governs relations of dependence and prevents any abuses of trust. These are the means toward human flourishing that can be promoted and protected. Thus, the private and public dichotomy which is fundamental to classical/traditional liberalism and which is used as reason for not interfering with contracts, is substantially blurred. Accordingly, the circumstances that warrant legal action and those that warrant moral sanction are blurred as well.

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[24] Section one of the *Canadian Charter of Rights and Freedoms* reads: "The Canadian Charter of Rights and Freedoms guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society." *Constitution Act, 1981*, Part 1, Schedule B.

[25] Collins, p. 13.

[26] Collins, pp. 13-14.

[27] Collins, p. 14.

Collins sees modern law as moving towards the "broadest conception of paternalism"[28], that is, "opposing any freedom of the parties to choose the terms of contract".[29] While those who believe that physicians have far too much power over their patients may appreciate this suggestion, it is too strongly stated and far from ideal. Although the courts can invoke standards to disallow some contracts as well as establish or prohibit various sorts of transitional relations, these constraints do in fact allow for some latitude.

One can offer limited support for Collins' position by pointing out that modern contract law is opposed to any absolute, non-restrictive freedom and as such modern law goes against classical liberal individualist theory. This is a rejection of the individualist claim that persons are always free to determine all the terms of contract. Instead, persons are only free to determine the terms of contract within the parameters set by the state. Courts are to impose model contracts upon the parties or extend bargaining in good faith so that the "dominant party must confide in the weaker and instruct him with sound advice".[30] Collins admits that paternalism can, in practice, reduce the wealth of one party but this is only seen as one possible spin off. The aim however, is to "redress the balance of power" so that the original contract is restored to "a state where the terms are fair".[31] The purpose of all of this is to adjust the relations of power with an eye on respect and dignity of the parties concerned. While this entails a balancing act, it should not be interpreted as simply providing us with an excuse for knocking the powerful down a notch or two. Punishing the stronger may serve only to reverse the status of parties by simply replacing one weak and/or victimized party with another. Instead, by adjusting the power levels, the contracting parties parties are placed under different obligations. Physicians are, among other things, to treat patients with dignity, to respect the choices of the competent and to impart to the best of their ability the skills that they have learned as healers. They are also free to refuse to accept such implicit obligations by not entering into the contract in the first place for personal and professional reasons. Patients play an equally important role in the contract and should be equally accountable to the rules of the contract. Patients are to be honest, forthcoming and respect the professional integrity of physicians. They also have the right to accept or reject medical treatment that is offered to them.

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[28] Collins, p. 115.
[29] Collins, p. 115.

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[30] Collins, p. 116.

[31] Collins, pp.151-159.

III. Corporatism and the Community.

According to Collins, the courts are to act in a paternalist manner in order to promote fairness, trust and cooperation. Nevertheless, in doing so, one must not forget the original intent of enforcing contractual agreements, that is, to provide efficient and reliable means for the production and distribution of goods and services.[32] To accomplish this, Collins introduces the notion of "corporatism".[33]

Under corporatism, state-sanctioned representative groups negotiate the acceptable standards of behaviour that are to be applied. This direct removal of the courts from the market avoids crushing competitive motivations and overbearing governmental intrusions upon productive and distributive freedoms. The corporatist response has four components: negotiating standards, arbitrating between grieving parties, backing up decisions with legal sanctions resulting from their state decreed powers and, finally, a judiciary review where the state keeps the groups in check.[34] In maintaining this corporatist view, the fears of those from the traditional school are alleviated and individual liberty is kept in its proper place as compared to the other modern social values expressed. Perhaps, then, we might view the regulatory bodies of the medical system (primarily the College of Physicians and Surgeons) as capturing a simplified version of this corporatist view.

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[32] Collins, p. 204.

[33] Collins, pp. 203-209.

[34] Collins, p. 205.

The courts are always hesitant to step into medical issues and proceed very cautiously when they do.[35] On this point, we have already expressed concern regarding turning the decision-making process over to a professional-centered ethic. Having the ethical codes of the College of Physicians and Surgeons sanctioned by the community acts to alleviate the potential abuse or appearance of abuse that would be possible if the profession's rights and obligations are not facilitated or reviewed by the community's input. This input is exemplified through various actions and committees including, but not limited to, ensuring educational standards, *de facto* moratoriums, social regulatory boards, judicial input, external review boards, ethic committees, national or provincial referendums, the de-listing of medical services and so on. All of these avenues serve the members of the community by providing sober and informed power over the corporatist self-regulatory approach that Collins favours. Of course, we always need to remember that this community includes *both* the physician and the patient.

In reality, contracts in medicine are more than just one-to-one transactions as there are many more players in the background. Those directly or indirectly involved can include the health care providers, the profession, the hospital staff and administration, the medical institution, government, spouses, family, guardians, other professionals and various members of the community. As such, these contracts should incorporate the social values of those affected since connections with the community at large are not merely a result of the fact that the community often holds the financial purse strings in medical contract. Acknowledging the integral connections between the well-being of the community and its members can also be used to alleviate various concerns that physicians (and others) have about reducing the physician-patient relationship to a series of simple legalisms.[36]

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[35] For example: *Re S. D.* (1983) 3 W.W.R. 618 (B.C.S.C.).

There need not be an inherent conflict between individual and collective interests. In fact, a community can flourish only if and when (at least some of) its individual members are flourishing and, in turn, members of the community can only flourish within a larger social context. It is important, then, for the community to care for its members and to ensure that it is a society worth belonging to. The interconnectivity between the community and the individual creates a valuable symbiotic relationship.

Collins has presented us with a very structured and rigorous position -- one that goes against many perceptions of how contracts seem to work. Clearly, the fine details and complexities of his view cannot be captured in a few pages but the role of paternalism and corporatist movements has been presented. Unfortunately, the spirit of Collins text suggests that there are some areas that need clarification to help our own cause.

The first thing one is made aware of is Collins' claim that modern law of contract is moving away from individualistic values towards communitarian values. This claim rests upon the assumption that the law of contract is, in fact, based on societal values and general moral principles as opposed to, for instance, pure economic efficiency. This latter assumption may be acceptable if one pushes the concepts hard enough. For example, the grounds for an economic theory are based on the singular idea that economic efficiency is good and, hence, desirable. Consequentially, if efficiency is desirable, then it has societal value. Of course, that society has in fact moved in this direction is more contestable.

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[36] Two such persons concerned with this are R.H.Fisher and E.M. Meslin "Should Living Wills Be Legalized?" *Canadian Medical Association Journal* 1990, 142:23-26

In support of Collins' claims, we note that J.M. Beerman believes that: "Collins makes a good case that current law has strayed from the classical uninhibited market model"[37] and proceeds to argue own his case in favour of communitarianism as its replacement. Others have plausibly argued that some communitarian aspects have always been present in one form or another in the law and have played some role in some judicial decisions since the nineteenth century.[38] Accordingly, Collins' angle on law of contract is perhaps not as radical as some may suggest. However, if we focus our attentions on the values promoted by Collins, it is clear that one could find room to argue that communitarian aspects of the law of contract do not presently exist. One must recognize that his perspective on the capacity of common law principles to change with the times is not a widespread belief. More to the point, Collins fails to acknowledge the role of desert and he over emphasizes the attractiveness of the state to carry out paternalist intrusions. As we'll argue presently, we must favour the view that Collins either is presenting a faulty *description* of the law of contract or is offering a *prescription* of the law of contract. While it is more likely a combination of both error and prescription, we hope to build upon most of the elements of Collins' interpretive characterization while isolating the more controversial areas.

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[37] Beerman, J.M. "Contract Law as a System of Values" *Boston University Law Review*, May 1987, p. 554.

[38] Dare, Tim "Collins and Contract", unpublished, 1988

In considering the difficulties in Collins' work, we note that Collins fails to consider the following question: "If the priority of liberty has diminished in favour of the priority of communitarian values and given the supposed value of paternalism, why are specific parties held accountable for their contractual agreements?" Could it not be the case that communitarian values may be better achieved by other means than by allowing and regulating specific persons to contract and enforce respective duties upon said parties? For example, there may be cases when a party other than the contractors could easily fulfill the obligations set out. Collins does not offer an objective criterion for evaluating the aims of modern law concerning special treatment and paternalistic intervention when parties are needy or when others could act from a more powerful base. "When", asks Feinman, "is the price too high? And how much superiority in bargaining is too much?"[39]

Under communitarian ideals, we may wish to lower the subjective value of the service or item and, in turn, lower the contractual price. For individualists, this is clearly an objectionable and unfair infringement even though the law presently seems to act as if the most efficient means to obtain communitarian values is by putting paternalistic market controls in a variety of areas of commerce (e.g., price gouging is considered illegal and standard fees are set for various medical services). To complicate matters, the law also acts to affirm traditional individualistic values by sometimes holding people to their obligations simply on the grounds that they voluntarily assumed them.[40] It may seem, then, that there is an inconsistency here or at least some sort of struggle between communitarian and individualist values, however, we do not have to accept such a conclusion.[41]

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[39] Feinman, J.M. "Contract After the Fall", *Stanford Law Review*, July 1987, p. 1550.

One solution to our query about why Collins does not account for the right of specific individuals to contract as opposed to the forced redistribution of contractual obligations can be found within the notion of "desert". Collins refers to "respect" and "dignity" but does not tell us why particular individuals are deserving of "special status" such that others are to be forced into regulating their own behaviour and weaken their already established bargaining position. That such an imbalance may exist does not in itself produce reasons for establishing paternalistic guidelines that deem certain rates of power or wealth as being improper. To affect a person's bargaining power may entail unjust harm regardless of whether that person is in the stronger or weaker position.

Collins' theory of paternalism requires additional explication and justification. Maintaining that the broadest conception of paternalism is to be valued pushes the concept of paternalism into such intrusive and far reaching areas that many who may initially find paternalism a palatable option will find Collins' extension distasteful. Enforcing, altering or voiding contracts on the basis of supporting the weaker party can create varying difficulties depending upon whether the person or persons affected are the contracting agents or are persons who are ultimately affected by the contractual outcomes. Dworkin contrasts "pure" paternalism -- the view that one's liberty may be interfered with for one's own benefit (e.g., saving a clinically depressed person from harming him/herself) with the substantially different notion of "impure" paternalism - where one's liberty is interfered with for the sake of benefiting another.[42] If law of contract is conceived as acknowledging the right to individual liberty, then a case can be made for justifying pure paternalism on the grounds that such an intervention is motivated by the promotion of the autonomy of the same individual. Thus, we might attempt to prevent the depressed person from entering into an agreement with a physician who is willing to assist his/her suicide.

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[40] My thanks to Roger Shiner, University of Alberta, for highlighting this essential component of contract.

[41] For a classic discussion of the issue of paternalism and the law see: Duncan Kennedy, "Distributivist and Paternalist Motives in Contract and Tort Law", *Maryland Law Review*, 1982, Vol. 41, no. 482.

Consider how paternalism fits into the communitarian scheme of enhancing trust and cooperation -- two concepts that play a significant role in the physician-patient relationship. If state intervention forces parties into unwanted situations where the contract is radically altered by the state, then trust and cooperation may be harder to obtain because of the resulting insecurity due to the potential for future interference. What must be avoided is an *ad hoc* appraisal of contractual agreements.

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[42] Dworkin, G. "Paternalism" in **Morality and the Law**, ed. Richard Wasserstrom (Belmont, California: Wadsworth Publishing Company Inc., 1971).

Accordingly, rules for agreements should be set out prior to any sort of consideration or contractual discussion by parties (whether they be business transactions or transactions between health care providers and patients). Pre-arranged agreements in medicine would be the sorts of agreements established by a communitarian contract system. These agreements may be viewed as constraints but they are such that they allow the parties a significant degree of maneuverability. That a party is weak or is open to exploitation does not entail that he/she does not wish to enter the agreement nor does it mean that the party fails to appreciate the nature of the contract that he/she is entering into. The party may still wish to pay the price required and may believe that the transaction is, and will be, acceptable by the other party.[43] Given the second party's wish to contract as well, the transaction can take place and, hence, there is trust in the other party's taking on liability. Furthermore, we now have reason to act in good faith and, hence, there is cooperation. Thus, one way to get Collins to drop the need for excessive intrusions in contracts is to point to the fact that the persons involved in the contract voluntarily entered into it under an umbrella of pre-established contractual conditions which they implicitly accepted. This point places the burden on others to dispute the validity of the agreement reached. It is in this manner that individual freedom to contract can be protected and, hence, these individuals can be held accountable for the consequences of the contract.

It may just be the case that one of the fundamental values that the community holds dear is autonomy. As we have mentioned previously, some forms of paternalism need not be in conflict with this valued principle. If there is no conflict, then paternalism is one way to satisfactorily maintain a communitarian approach as well as recognizing the importance of individual freedom to contract. Paternalism, in the sense of setting limitations on what can be done and in the sense of imposing obligations, can assist the person who is in a weaker bargaining position by extending his/her potential to be autonomous. Patients (competent or not) are generally in the weaker position so ethical guidelines governing the physician-patient relationship are such that patients are protected from their own lack of knowledge or from undue influence or duress. Within the medical context, we see health care providers working towards this goal when dealing with patients. For instance, after learning of the seriousness of their medical condition, counseling may be provided to patients in order to give them necessary time, information and coping skills so that they regain the ability to freely choose what is in their own best interests. Accordingly, it is important that the physician not rush to pursue delicate matters such as Do Not Resuscitate Orders.

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[43] As an example of an extreme case, wanting to contract for assisted suicide need not be irrational given the alternatives in many cases.

Of course, just because one party is in a weaker position than the other, does not entail that harsh obligations should be imposed on the second party. That I do not have the necessary funds to purchase an automobile justifies the car dealer's refusal to accept my offer. However, that I do not have the necessary funds for putting a roof over my head or for a medically necessary procedure should not be grounds for being denied a minimal amount of shelter or basic medical attention. Unlike the previous situation, where my subjective interest could be met by settling for a less expensive form of transportation, the latter situation is an attempt to promote or maintain a basic level of welfare for community members. It is in these sorts of cases, where the consequences of unequal bargaining power has fundamental and significant impact on the objective interests of individuals, that the issue of fair contracts is most important.

Fundamental social values are to be promoted under the schema of regulating market transactions, whether they involve the buying of a car or medical care. Unfortunately, Collins turns to the market itself for verification of the truth or acceptability of the fundamental values and this leads to difficulties that the more cynical of us might refer to as "letting the fox guard the hen house". Collins suggests that if a contract fits in with the competitive market, then this is a good reason to believe that the contract is fair. It is with this reasoning that he interprets *Toker v Westerman.*[44] In *Toker v Westerman,* it was found that the actions of a door-to-door salesman who sold a refrigerator for $1229 were unconscionable because the same item was selling for $400 in the stores. Collins would reject the obligations of the contract on the grounds that it was unacceptably out of touch with the market price. But, if the prices were reversed, that is, if the salesperson had sold the appliance for $400 and the market price was $1229, Collins would have to maintain that the contract is unenforceable given that it did not meet the market standards. Surely there are plausible scenarios when such a contract would be binding on both parties if the above sort of case were true (e.g., so-called "loss leaders"). When one appeals to the market for standards, there remains the problem of determining independently when the market is acceptable, otherwise one is at risk of creating artificial standards and practices which do not coincide with an objective evaluation of the situation. This has the potential to beg the question. It is Collins who puts forward the challenge of an "objective evaluation of the market" and, thus, he needs to appeal to some higher order principle to thwart the injustice or the perception of injustice in cases of self-regulation. In parallel with this state of affairs, one should look to the values of the community as a means to establish objective evaluations in cases that appear to go against the "medical market" and which seem inappropriate. Alternatively, the community may be placed in the situation of determining what the parameters of the market are, including what is permitted in the market in the first place. It is this last mentioned approach that is stressed in the 1993 Canadian Royal Commission on New Reproductive Technologies when they speak of limiting access or banning medical treatments and experiments with reference to the values of Canadians.[45] Feinman also speaks of the need for higher order principles when he states the following in a review of **The Law of Contract**: "If law is social modes of conduct combined with legal norms, it must embody some source for legal standards other than the market standards themselves."[46]

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[44] Collins, p. 144.

Collins sets out a very rigorous and demanding social role for modern law of contract and then leaves it up to various interest groups to faithfully create the accepted standards and then carry out fair market transactions.

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[45] See Royal Commission on New Reproductive Technologies, **Proceed with Care: Final Report of the Royal Commission on New Reproductive Technologies**. (Canada. 1993).Ch. 2,3.

[46] Feinman, "Contract After the Fall", p. 1547.

Yet, people like Beermann are rightfully troubled and wonder why "Collins thinks that contemporary corporatism is a good thing".[47] Beermann further notes that:

> Nothing in the organizational structure of such (corporate) institutions makes me confident that the organizations are looking out for the welfare of the weaker members of society who are affected by their polices...(as these groups) often seek government regulation to protect their member's profit margins...that the groups seek their own welfare does not entail that they seek the welfare of others.[48]

Collins presents us with a dilemma: either he allows corporatism to determine and establish market standards and, thus, risks the creation of objectively unfair market standards due to the self-interests of the groups involved; or judiciary review committees are permitted to step in and disarm the competitive nature of the market, thereby infringing upon the autonomous right to contract. Fortunately, the liberal communitarian can resolve this dilemma without imposing impure paternalism and without remaining individualistic by insisting that the community define these broad parameters in which the contracting parties are allowed to move freely. This desire to establish independent and objective criteria for determining the fairness of the contractual transactions in medicine is perhaps most crucial in terms of the overall effects and risks to the community. Hence, this element separates the self-regulatory corporatist approach from the communitarianist approach that rightfully seeks input and guidance from all the players. With active community recognition of the importance of autonomy and well-being of its members, it is recognized that the well-being and flourishing of the community relies upon its having a dynamic and reciprocal relation with its members. Accordingly, those who are affected play a role in establishing, or agreeing to, the constraints and freedoms that are set out to govern physician-patient relationships.

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[47] Beermann, p. 563.

[48] Beermann, p. 563.

CHAPTER SEVEN

Consent and Competency

I. Introduction.

To promote the efficiency and effectiveness of contracts, we must ensure that they are stable and predictable and that those who are party to the contract are held accountable. For this to be the case, it is important to ensure that the parties are capable of forming the intention to contract, and once the intent is present, that they understand what they are getting into. If parties are incapable of consent then it is important that their representatives are able to adequately represent their best interests.

We recognize that simply because one is incompetent does not rule out the possibility of contract. Minors who may be considered incompetent can contract for necessities. As well, third parties as surrogate decision-makers can, out of necessity, be responsible for the incompetent's contractual obligations. Although third party arrangements are popular, we should be reasonably skeptical about their ability to reflect the objective and subjective interests of the patient. The problem is that such contracts shift the burden of responsibility onto the legal guardian and, in doing so, they shift the freedom to contract onto someone who is not directly affected by the contractual agreement. Although the third party (whether it is a spouse, family member, friend of the patient, the court) may appreciate what the individual may have wanted at one time or another, there will always be an inherent level of ignorance and uncertainty. Although third parties may rely upon advance directives, as they provide insight into the views of the patient at the time of their writing situations, the patient's values and beliefs may change over time. Thus their current wants will not be reflected in the written document. Moreover, it is not always the case that third parties are genuinely interested in promoting the interests of the incompetent patient. For example, in *Re Eve*, Mrs. Eve sought to get her mentally handicapped daughter Eve, sterilized because of two concerns; that it would not be in the best interests of Eve to remain capable of bearing children, and, if Eve did have a child, that Mrs. Eve would most likely have to become the primary caregiver for her grandchild. The Supreme Court of Canada rejected both reasons arguing that the sterilization was non-therapeutic and it was a grave intrusion upon Eve's rights.[1]

Once we determine that an individual can or cannot consent to certain acts and once we start manipulating the parameters in which individuals can freely act, we are prescribing limitations upon the abilities of individuals to exercise self-determination. Hence, it is important that we be able to distinguish between who should be classified as competent or incompetent so that such intrusions are demonstrably justified. Accordingly, we begin by discussing the concept of informed consent since it relates to the issue of decision making. We shall then proceed to look at the issue of competency and determine which individuals have the right to make decisions on their own behalf.

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[1] *Re Eve* (1987), 3 D.L.R. (4th) (S.C.C), (1987) 2 S.C.R. 388 (S.C.C.).

II. Informed Consent.

When we talk about the rights and duties of patients and physicians and suggest that community constraints and regulations ought to govern their relationships, we note that one of the most important rights that patients have is their ability to exercise the freedom to accept or refuse medical treatment. Physicians are obligated to respect and promote this right by providing patients with all reasonable data concerning diagnostic and therapeutic procedures, as well as the possible alternatives and material risks involved.[2] Physicians are also obligated to permit patients to make their own decisions without coercion or duress. Competent patients are permitted to make unfortunate or foolish decisions and if the personal views of the physician are incompatible with those of the patient's, then he/she may conscientiously object and refer the patient to another physician.[3]

Getting informed consent requires not just getting the patient's signature on a piece of paper or having the patient "parrot" back (i.e., repeat without comprehension) the information to the physician. Rather, it is an offer and an acceptance and, as such, consent can signify the true desires of the patient to form a contract with the physician. It is also important that a suitable standard of competency be in place so that the interests of competent and incompetent patients, as well as their caregivers, are duly protected.

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[2] See "Informed Consent: Ethical Considerations for Physicians and Surgeons" *Annals of the Royal College of Physicians and Surgeons of Canada* 21:1 (1988).

[3] For further exploration of this see: Eike-Henner Kluge, "After 'Eve' Whether Proxy Decision-Making?" *Canadian Medical Association Journal,* 137 (Oct 15, 1987), pp. 715-720.

Decision-making competency is one of three necessary components in a standard analysis of the requirement for informed consent; the other two components are that the consent be given freely and that it be informed. Consent must be given freely otherwise it will likely serve someone else's needs and does not (I might add) reflect the patient's intent to contract. Consent must be informed, otherwise the patient will not be able to ascertain how alternatives might serve his/her aims.

Voluntary and informed consent is often a matter of degree. Achieving true informed consent is impossible if by 'informed' one means 'completely informed' since disclosure of *all* information is practically impossible.[4] Add to this the fact that some patients may have difficulty with the language and may be uneducated and you have the makings of an argument for physicians to become paternalistic. However, these facts should not be used as an excuse for physicians to claim that since they cannot inform patients of the whole truth they should not attempt to get any degree of informed consent.[5] By arguing that it would be in the best interests of the patient for the physician to assume full responsibility of the decisions made and actions taken, physicians would fall back into the authoritarian model.

Instead, physicians should strive towards a measure of reasonable disclosure. Getting informed consent from competent patients can be a challenge because the parties involved bring radically different backgrounds to the table. The physician brings to the medical relationship his/her medical knowledge and training while the patient brings his/her aims and values. Accordingly, it is important that both sides know what the other side is aiming towards. To achieve reasonable disclosure and informed consent, the physician needs to gain more information about the patient as a whole person so as to provide appropriate and better care. By doing so, the physician is able to carry out his/her own professional obligations more effectively. The physician also needs to have a good understanding of the patient as a person so that he/she can provide that relevant information which will permit the competent patient to reflect and evaluate the information in relation to his/her needs and interests.

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[4] See for example, Mack Lipkin, "On Telling Patients the Truth", *Newsweek*, 4 June 1979, p. 13.

[5] See for example, Sissela Bok, "Lies to the Sick and Dying", from **Lying: Moral Choice and Private Life** by Sissela Bok (New York, Pantheon Books :1978) pp. 221-223, 234-240.

Since fully informed consent can never truly be achieved, some may claim that physicians shouldn't tell their patients anything and should instead personally assume the responsibility of their patients' well-being. While this might be seen as an unjust and paternalist reaction, we can appreciate that such a move is motivated by the physician's reliance on the Hippocratic tradition. Nevertheless, such a move is unnecessary for Freedman writes:

> When the doctor wishes to insert a catheter, must he commend to the subject's attention a textbook of anatomy? Must the patient be informed of the chemical formula of the catheter? It's melting point?[6]

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[6] Freedman, B. "A Moral Theory of Consent" in Kluge, E-K. (Ed.) **Readings in Biomedical Ethics: A Canadian Focus** 1st ed. (Scarborough: Prentice Hall Canada, 1993) p. 145.

A patient ought not to need a medical degree or university training in physics and chemistry to understand or appreciate the information that is being imparted to him/her. A patient does not need to know the chemical make up of a catheter to decide whether to agree to its insertion. The patient does not need to know the odds of lightning striking the hospital during the surgery; nor does the patient need to know the color and sizing of the surgical gowns that will be worn. Thus, being truthful towards the patient need not be an onerous task and, accordingly, not being truthful (in the sense of withholding information) requires justification such as the patient explicitly expressing his/her desire not to know "all the gory details".[7]

The kinds of information mentioned in the above quotation are irrelevant for many patients. They are more concerned about knowing how much the treatment will hurt, whether it is necessary, if it will help, what the material risks are and whether there are less intrusive and burdensome alternatives which will provide similar desirable results. Information that will supply answers to these questions is directly relevant to the patient's being able to make an informed choice. As such, this information will provide the patient with a better opportunity to act in accordance to his/her subjective interests since, without the proper information and understanding, he/she may decide to do that which he/she would not have chosen had he/she not been ignorant of the situation.

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[7] For contrasting views on the topic of withholding information, see Mark Lipkin "On Telling Patients the Truth" and Sissela Bok "Lies to the Sick and Dying" both reprinted in Munson, Ronald ed., **Intervention and Reflection: Basic Issues in Medical Ethics** 5th ed., (Belmont, California: Wadsworth, 1996).

Benjamin Freedman is quite right to point out that by focusing on the difficulties of fully informed consent, people fail to consider the human purpose behind the information. For Freedman, the proper question is not "What information should we give?" but rather "Why should the patient be informed at all?" The answer, says Freedman, is:

> The patient must be informed so that he will know what he is getting into, what he may expect from the procedure, what his likely alternatives are, and in short, what the procedure will *mean* to the responsible individual.[8]

Freedman suggests that a responsible individual is one who makes choices on the basis of reasons, arguments or beliefs and remains open to the claims of reason. Responsible individuals are those who are capable of making and carrying through with a life plan and who are prepared to act on their reasoned choices and live with the consequences. [9] Such individuals are personally and actively engaged in creating, shaping and controlling their lives in accordance to their subjective and objective interests.

Valid consent also requires that the consent be freely given. Aside from abstract debates regarding determinism, the notion of voluntariness entails that the person not be coerced and not be under duress. This leads to some concerns regarding how voluntary patient decision-making actually is since a person's being in the hospital setting under a physician's care suggests that the patient has already lost some personal control. The various rigid institutional structures and guidelines that are in place can hamper a person's ability or desire to act. Being in the hospital can be somewhat intimidating and threatening to a person's sense of control and the hospital setting may cause individuals to make decisions that they normally would not have made as they may be overly affected by emotion, fear and/or medication. Although it would benefit patients to sign informed consent forms in the less-threatening environment of the physician's office, this procedure is not always followed. In an on-going study, Claudette Kelly found that:

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[8] Freedman, in Kluge, p. 146.

[9] Freedman, in Kluge, p. 148.

> In interviews with 21 patients who shared their decision-making experiences as they relate to a recent hospital experience, the vast majority of patients stated that they had signed their consents either on admission to hospital or in the day surgery area. All but a few had no idea what their consent stated. While some of them had received an explanation they understood from their surgeon, many had not.[10]

One's being instructed as to the various risks and treatments at the time of this discovery may not serve as an effective vehicle for the patient to acquire the necessary medical information required in order to make an informed decision. In such situations, the patient may not be readily able to absorb and reflect upon the information provided. As well, the disease or trauma that the person is suffering from can impinge upon his/her ability to act and guide his/her own life as he/she desires. Accordingly, the patient is vulnerable to any outside suggestion that comes from an authority figure. For example, the physician who disagrees with a patient's choice may influence the patient's decision either intentionally or unintentionally by selecting certain phrases over others that have positive or negative connotations or by emphasizing one option over another. Promoting patient education[11] and physician-patient communication[12] are two ways to try and promote the patient's ability to successfully participate in the decision making process.

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[10] This piece of research is in its early stages (as of March 1998) and is being conducted jointly by Dr. Claudette Kelly, University College of the Cariboo, Kamloops, B.C. and Dr. Kim Lutzen from the Karolinska Instituted in Stockholm, Sweden. Quoted text kindly provided to the author by Dr. Kelly in personal correspondence.

Recognition of what consent entails, as well as recognizing when person's are able to consent to contract gives more authority to the patient by providing him/her with greater participatory roles in the decision making process. Nevertheless, it is true that there are patients who might think along the lines of: "I should do what he tells me simply because he's my doctor". What may be even worse than this is that some patients force their physicians into assuming a greater authoritarian role by uttering such things as: "Do whatever you think best, Doc!" By giving more control to patients in terms of requiring informed consent, we are also asserting that patients should take greater responsibility for their own decisions. By playing a more active part in the outcome, patients are exercising their autonomy. Nevertheless, patients may refuse to accept responsibility and decide to hand over the decision-making to the medical experts. Still, those persons who are elderly, ignorant or scared and those who do not want to exercise their full participatory rights in the decision-making process are not necessarily in conflict with the principle of autonomy. One is still acting autonomously when one *freely chooses to be dependent* upon a physician. It is hoped that in such cases the physician is comfortable in assuming this role to act on behalf of the patient. Here, the physician must be knowledgeable and responsive to the patient's objective and subjective interests and share or (at least) appreciate the patient's values. Since the physician is assuming a role that was voluntarily given to him/her by the patient, the subsequent decisions that the physician makes on behalf of the patient should not be seen as violating the patient's autonomy, but as an extension of it. Of course, the physician is also within his/her rights to refuse to accept responsibility for making the necessary decisions.

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[11] See for example: Karyl Woldum, et al, **Patient Education: Foundations of Practice**, (Rockville, Maryland: Aspen Publication, 1985), Kate Lorig, **Patient Education: A Practical Approach** (Mosby Year Book, 1992).

[12] The health care provider must be vigilant to look for other signs of communication besides direct verbal expressions.

In order for a person to make an informed and valid decision there must be disclosure. Accordingly, it is important in the health care provider-patient contract that the physician gives options and uses language that is clear, neutral and understandable. Indeed, the physician may require the use of diagrams or sign language so that the particular patient understands the information. In the case of small children, even though their consent is not legally required, it may be beneficial to the child to attempt to explain (by the use of the use of mock surgeries on puppets, animated videos, etc.,) what he/she will be going through in order to ease some of the natural fears that are associated with the stressful situation.

The Canadian standards for whether a patient is informed stems from *Reibl v. Hughes.*[13] In this 1970 case, a patient, aged 44, underwent surgery and, unfortunately, during or immediately after surgery suffered a massive stroke which left his right side paralyzed. The patient had consented to the surgery, but alleged that it was not "informed consent". He sued for damages on these grounds as well as grounds of battery and negligence and won $225,000. This judgment was reversed by the Ontario Court of Appeal and then was appealed to the Supreme Court of Canada. What was at issue here was the question of whether the patient was properly informed and, secondly, if he was not informed, would he have opted for the surgery if he had been. The Supreme Court of Canada had to consider the more abstract question of what counts as the standard for disclosure and being informed.

The subjective standard of disclosure, namely: "Whether if informed, the particular patient would have foregone treatment" [14] was rejected as inappropriate by Justice Laskin who cited an earlier rejection of the subjective test: "The subjective standard has a gross defect: it depends on the plaintiff's testimony as to his state of mind thereby exposing the physician to the patient's hindsight and bitterness."[15]

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[13] *Reibl v. Hughes*, 16, O.R. (2d) 306, 78 D.L.R. (3d) 35, reversed 21 O.R. (2d) 14,6 C.C.L.T., 227 89 D.L.R. (3d) 112, reverse (1980) 2 S.C.R. 880, 14 C.C.C.T.I., 114 D.L.R. (3d) 1, 33 N.R., 17.

[14] "Informed Consent -- A Proposed Standard for Medical Disclosure" 48 *N.Y.U.L.* Rev. 548 (1973), p.550. Cited in *Reibl v. Hughes*, 16, O.R. (2d) 306, 78 D.L.R. (3d) 35, reversed 21 O.R. (2d) 14,6 C.C.L.T., 227 89 D.L.R. (3d) 112, reverse (1980) 2 S.C.R. 880, 14 C.C.C.T.I., 114 D.L.R. (3d) 1, 33 N.R., 17.

[15] "Informed Consent -- A Proposed Standard for Medical Disclosure" 48 *N.Y.U.L.* Rev. 548 (1973), p.550. Cited in *Reibl v. Hughes.*

On the other hand, the purely objective standard of disclosure which asks: "What would a reasonable person want to know?", is problematic in that it "seem(s) to put a premium on the surgeon's assessment of the relative need for the surgery and on the supporting medical evidence of that need."[16] The court opted instead for a objective test that would acknowledge the reasonable concerns of the patient such that the test would be presented in terms of: "What would a reasonable person in the patient's situation want to know?" This was an important step in promoting patients' autonomy and reflects the need for a case-sensitive standard. Each patient's needs and desires differ, and what may be reasonable for a young married person with a new family might not be appropriate for the older gentleman about to retire:

> The adoption of an objective standard does not mean that the issue of causation is completely in the hands of the surgeon. Merely because medical evidence establishes the reasonableness of a recommended operation does not mean that a reasonable person in the patient's position would necessarily agree to it if proper disclosure had been mad of the risks involved. The patient's particular situation and the degree to which the risks of surgery or no surgery are balanced would reduce the force of the surgeon's recommendation.[17]

The Canadian Supreme Court found in *Reibl v. Hughes* that the patient was not fully disclosed of all the material risks surrounding the medical procedure, including such information as the percentage of deaths in previous operations. Notice however, what counts as non-disclosure of material risks may vary from patient to patient. Not only should the medical information be imparted, but information that is specifically relevant to the individual patient should be acknowledged. Accordingly, what information is disclosed and how it is disclosed should be tailored to meet the needs of the patient. For example, a patient may wish to know all the gory details of his/her operation, while another may wish to waive any questions about risks because he/she "just does not want to know". In the latter case, the physician may be justified in being less specific or withhold certain distressing information from the patient (e.g., that there will be a lot of post-operative pain).[18] Laskin writes:

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[16] *Reibl v. Hughes*, 16, O.R. (2d) 306, 78 D.L.R. (3d) 35, reversed 21 O.R. (2d) 14,6 C.C.L.T., 227 89 D.L.R. (3d) 112, reverse (1980) 2 S.C.R. 880, 14 C.C.C.T.I., 114 D.L.R. (3d) 1, 33 N.R., 17.

[17] *Reibl v. Hughes*, 16, O.R. (2d) 306, 78 D.L.R. (3d) 35, reversed 21 O.R. (2d) 14,6 C.C.L.T., 227 89 D.L.R. (3d) 112, reverse (1980) 2 S.C.R. 880, 14 C.C.C.T.I., 114 D.L.R. (3d) 1, 33 N.R., 17. Cited in Kluge, E-K. **Readings in Biomedical Ethics: A Canadian Focus** (Scarborough: Prentice Hall Canada, 1993) p. 137.

> It is, of course, possible that a particular patient may waive aside any question of risks and be quite prepared to submit to the surgery or treatment, whatever they be. Such a situation presents no difficulty.[19]

The difficulty surrounding informed consent and the need to increase the knowledge base of patients in a complex and frightening environment has lead some hospitals and enterprising businesses to develop interactive video presentations that patients take home and review after consultation with their health care provider.[20] This manner of presentation allows patients to review the material at their leisure once the shock of receiving the bad news has subsided. Providing the patient with clear and understandable medical information puts the patient in a better position to return to his/her physician and ask more questions. Once the patient receives appropriate answers to the questions, the patient can then reasonably refuse or accept treatment. This chain of events reflects the right of individuals to determine the course of their own lives. Such disclosure and support also helps restore the imbalance of power by making the patient more aware and, hence, more apt to act in accordance with their own best interests.[21] Still, even though the physician may go to extra lengths to disclose information, the patient may still not understand. In such cases, one may suspect that the patient is incompetent to make a decision about their own health care.

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[18] Withholding information from a patient requires substantial justification. Physicians should not assume that the patient would *not* want to know.

[19] *Reibl v. Hughes*, 16, O.R. (2d) 306, 78 D.L.R. (3d) 35, reversed 21 O.R. (2d) 14,6 C.C.L.T., 227 89 D.L.R. (3d) 112, reverse (1980) 2 S.C.R. 880, 14 C.C.C.T.I., 114 D.L.R. (3d) 1, 33 N.R., 17.Cited in Kluge, E-K. p. 135.

[20] See Michael Decter's discussion of the patient becoming more active as a consumer: **Healing Medicare: Managing Health System Change the Canadian Way**, (McGilligan Books: Toronto, 1994) Ch. 9.

III. Incompetence and Surrogate Decision-making.

A natural and appropriate response to the question: "Is the individual competent?" is to ask: "Is the individual competent at what?" For, when we question whether an individual is competent or incompetent, it is often intended to be a question about the ability of a person to perform a specific role or task: "Is he a competent driver?", "Is she a competent artist?", "Are they competent parents?"

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[21] This bit of information also highlights how the entrepreneur can find new avenues of exploration and opportunity within the medical market place.

When we question whether the person is competent at some task, we must first establish that the question itself is applicable, since to ask "Are Wilma and Fred competent parents?", we are assuming that Fred and Wilma are parents. If Wilma and Fred did not have any children, the question of competency regarding their parental skills would be misplaced. If we ask instead "Are they competent *to be* parents?", we are asking about their overall maturity and specific talents.[22] Accordingly, we ask "Is the patient competent?" we are asking whether the patient is competent to make a decision regarding his/her health care.

In the matter of a patient accepting or refusing medical treatment, he/she must be able to evaluate the information and reason accordingly. Furthermore, if a person is judged competent, their informed decision must be respected regardless of how we may value their ultimate decision. Thus, being judged incompetent[23] has obvious and serious ramifications upon one's ability to exercise one's autonomy as it affects one's ability and opportunity to choose the pathway of one's life. It also raises paternalist concerns about the role of third parties as surrogate decision-makers since what the patient wants or what the patient wanted while competent may or may not be adhered to. If the patient is incompetent, the task to determine how to proceed is most difficult.

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[22] If the persons about whom we are inquiring are utterly without ability in their role, we sometimes say that they are so bad that they are not parents, or physicians, or professors. However, such a claim ought to be considered only in a metaphorical sense. If a person is emotionally or mentally unable to look after his/her children, we could comment that he/she is an incompetent parent but this evaluation does not affect the biological facts. Thus, it is one thing to say that a person fits into a category and another to say that he/she does not and a third to say that he/she is incompetent to perform within that category.

[23] I make this distinction since appearances can be deceptive and persons who are competent have been judged not to be and vice versa.

By means of advance directives or living wills, competent patients may opt for verbally expressing their desires to a family member or a close friend or they may simply ask the family member to make decisions for them if and when they become incompetent. The patient's motivation behind this is the continuation of self-determination and to ensure that his/her interests are acted upon when he/she is unable to directly advise others of his/her wishes. Unfortunately, the belief that the interest of the incompetent patient can be represented well by the judgments of surrogate decision-makers remains questionable.

Surrogate decision-makers are faced with the overwhelming task of trying to empathize with the patient in question and make crucial choices that will affect the patient's interests. In order to make appropriate decisions, surrogates may try to put themselves in the position of the incompetent person. Yet, because the surrogate is not the patient, then he/she will have an imperfect and incomplete understanding of the patient's thought processes, belief systems, subjective interests and values. There is always the possibility that the choices made by the surrogate may not match the choices that the patient would have made if he/she were competent. This is especially the case when the patient does not clearly discuss his/her preferences with the surrogate. Furthermore, some surrogates may find having such life and death decisions placed in their hands puts them in a very difficult position as they struggle with the idea that "letting someone die" or "killing someone" can sometimes be in the best interests of the person that they care so deeply about. Surrogates may be emotionally reluctant to make that final decision to stop life support if they believe that they are some how responsible for the death of the patient regardless of the truth of the matter. They may also want to refuse to accept the role of surrogate decision-maker but this decision also carries emotional baggage with it. Regardless of what decision they make, the surrogate (or the individual who refuses to be a surrogate) may continue to question whether they did the right thing.

The role of surrogates in cases where the patient has never been competent is even more problematic. In *Re Eve*[24], the court was asked to consent to the sterilization of Eve who was deemed mentally incompetent. Sterilization was not sought for medical reasons rather it was to deprive Eve of the capacity to become pregnant and to relieve her mother of anxiety about the possibility of Eve's becoming pregnant. This case brings out another limitation of surrogate decision-making: personal biases. Surrogates may place themselves in the patient's position, but may mistakenly make judgments about the quality of that patient's life on the basis of his/her own personal values. The mistake of substituted judgments involves the surrogate failing to frame the question along the lines of: "What would the patient have decided if he/she were competent to decide and knew his/her condition?" Instead, some surrogates are tempted to ask: "If I were that patient, would I want such and such treatment done or withdrawn?" Accordingly, there is a danger of a competent person discriminating against an incompetent one. The decision made by the surrogate will be unacceptable because the surrogate substituted his/her values for the patient's rather than substituting the actual patient's inability to choose with the fiction of their being able to choose. Hence, if someone other than the patient is making the decision, then the physician must consider the criteria used to reach that decision in order to ensure that the surrogate's decision does not simply reflect his/her own personal standards and values.

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[24] *Re Eve* (1987), 31 D.L.R. (4th) 1 (S.C.C.)., (1987) 2 S.C.R. 388 (S.C.C.).

The aim of substituted judgments is a worthy one as the judgment is thought to recognize the moral dignity and right to free choice of patients by determining the incompetent's actual interests and preferences. Since the incompetent patient cannot personally exercise this right, the court, or the family or the physician acts on his/her behalf. Unfortunately, properly conducted substituted judgments are problematic as well. Substituted judgments are based upon the following hypothetical situation: "If the incompetent patient was reviewing his/her situation as a competent person, what would he/she decide, taking into account his/her mental capacity as one factor in his/her decision?" Or, in more blunt terms: "Let's pretend that the patient can make a choice about what is in his/her own best interests".

According to Linda and Ezekiel Emanuel, patient/surrogate agreement on treatment decisions appears to only have a success rate of between 33-68 percent and the willingness of third parties to withdraw the medical support of their loved ones on the presumed wishes of the patient is 60 percent.[25] The cumulative effect of this data suggests that surrogate decision-makers carry out the patient's requests 20-41 percent of the time.[26] Clearly, if the numbers from this study are correct, then patients' interests are not being served or promoted by the directives of surrogates in a significant percentage of cases.

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[25] Linda L. Emanuel and Ezekiel J. Emanuel "Decisions at the End of Life: Guided by Communities of Patients" *Hastings Center Report* 23, no. 5 (1993), p. 7.

With all the various scenarios above pointing to the problems surrounding surrogate decision-making, it is clear that the standard that is used to determine if a patient is capable of giving valid informed consent to medical treatment will play a significant role. We do not want to have to rely on surrogates if we do not need to. Given that there are individuals who were once competent but are now incompetent and given that there are individuals who have never been competent, we need to ensure that the interests both sorts of individuals are protected. Furthermore, we equally cannot forget to protect the incompetent's representatives and those who are contracting for him/her.

IV. Competency.

In Buchanan and Brock's work **Deciding for Others**,[27] we are presented with an exhaustive account regarding incompetence. The context of Buchanan and Brock's discussion is within the framework of a commonly accepted division between global and local incompetence.[28] Global incompetence is that which pervades the whole of one's actions or inaction whereas local incompetence refers only to specific abilities or inabilities. The most obvious examples of each are patients who are in a permanent vegetative state, and children respectively. Societal constructs also play a role in such determinations since society decrees, for example, that minors are not competent to give consent even though there are individual minors who are quite capable of thoughtfully reflecting upon their situation and may understand the information that they are being told. Each of us is competent at some tasks and incompetent at different tasks. Most of us are competent to drive but few of us are competent to perform surgical operations. Moreover, (as many of us have probably experienced at one time or another in our lives) a person can be competent to make a particular decision or perform a certain action at one particular time under certain circumstances but incompetent to do the same under different conditions. A person may be able to drive to work on Monday and, yet, be incompetent to do so on Tuesday because he/she is overwhelmed by stress, depression, illness or intoxication.

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[26] Linda L. Emanuel and Ezekiel J. Emanuel, p. 7.

[27] Buchanan, A. & Brock, Dan **Deciding for Others: The Ethics of Surrogate Decision making**, (Cambridge University Press: 1989).

[28] Buchanan and Brock, pp. 15-22.

Law and social practices accept a presumption of decision-making competence for adults. That is, an adult is assumed to have sufficient capacities to make decisions and to warrant that others respect the decisions made. This presumption entails that others do not coercively interfere with the self-directed decisions made by individuals and is clearly related to the principle of autonomy. If I can choose how to live my own life, then I should have the liberty to act in accordance with those decisions and I should also be held accountable for those decisions.

Before we turn to examine Buchanan and Brock's account, let us first mention a couple of general accounts of competency that we do not find helpful. First, we wish to rule a standard of competency that looks at the age of the person in question either as a necessary or sufficient condition. Such an account would ignore the fact that some mature minors (i.e., children over the age of 12) are capable of giving informed consent. As such, a minimum age standard is discriminatory since it considers all persons of the same age to be equally competent or incompetent.

We do not want a standard of competency that just asks: "Can this person make a choice or express a preference?" Although this approach is consistent with the promotion of patient autonomy, it can lead to potentially harmful contractual situations. A person can satisfy this standard regardless of whether or not there are mistakes or defects in the reasoning process. A person may be able to state a preference but not understand the information provided or understand the significance of the consequences of the decision. This account not only ignores the type of decision and the complexity of the decision but also the situation that the person is presently in which can greatly affect their ability to make an appropriate choice. A person may be able to express preferences over some things but this does not automatically entail that he/she is capable of making prudent decisions about various health care matters.

A standard that maintains a person is competent only when he/she makes a reasonable choice is also unacceptable for our purposes. Such a standard looks to some external standard or value that may be inappropriate. What is considered 'reasonable' needs to be defined within a context that is specifically related to the person in question. The patient's values may be different than the values of those doing the assessment. Thus the judgement about the reasonableness of the decision is too subjective and open to abuse. Furthermore, this narrow standard may imply that the competent assessor put himself/herself in the position of the patient and ask whether or not he/she would personally make the same choice as the patient.

Checking to see if the decision is reasonable may be motivated out of the principle of beneficence, but it can lead to the severe restriction of patient freedom to choose what they believe is in their best interests. In such instances the State would be infringing on the freedom of the parties involved to by determining what constitutes a good decision. As the parties voluntarily entered the contract and have been informed of the relevant information, their willingness suggests that they accept the terms set out even though the terms may be viewed by outsiders as being harsh.

Determining competency on the basis of whether a person is capable or incapable of making a choice or stating a preference, or is of a certain age, is problematic since it is inappropriate to automatically disenfranchise a person's right to decide on *all* matters if he/she is judged incompetent to decide on *some* matters.

Since we do not want contracts that are unfair or that victimize the parties by either being too restrictive or not restrictive enough, none of the above accounts are appropriate for the contract theory of medical ethics.

Buchanan and Brock lay out a triadic account of competence that is more suitable to the kind of contract theory that we are putting forward than those previously mentioned.[29] It protects those who should be protected from their own poor choices and gives latitude to those who deserve it. According to Buchanan and Brock, to be competent, a person must a) possess the capacity of understanding and communication; b) have the capacity for reasoning and deliberation and, finally, c) have a set of values or conception of the good. Let us discuss each one of these conditions in turn.

Understanding and communication, among other capacities, allow a person to take part in the process of becoming informed. Accordingly, it is important that when the patient is being instructed about medical options, procedures and outcomes, the patient not need a medical degree in order to understand what is necessary to deliberate and ultimately make and express an informed decision. When one understands, then, presumably, one will be in a better situation to decide what is in keeping with one's own interests. Thus, being informed allows for greater expressions of autonomy.

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[29] Buchanan and Brock, Ch. 1.

According to Buchanan and Brock, understanding also requires the ability to appreciate the nature and meaning of potential alternatives. This entails that a person has the ability to know what the alternatives would be like and what it would feel like to be in different future states.[30] To appreciate the alternatives requires that the people undergo various experiences and then integrate this information into one's decision making. The authors note that, in young children, this ability is often prevented by the lack of sufficient life experience, while, in the elderly, it is hindered by their limitations to understand experiences radically different from their own.[31] Major psychological blocks and illnesses accompanied by fear, denial, delusion and/or depression can also significantly impair the appreciation of information about an unwanted or dreaded alternative.[32] It is crucial that these particulars be considered when one is weighing the reasonability of even the competent person's decisions.

However, is it possible to truly or fully understand and appreciate the nature and meaning of the alternatives? Is it possible to determine without actually experiencing the alternative, what the alternative would 'feel' like? One can imagine or understand the processes of medical treatments and imagine their consequences but not internalize the information. I may understand that you are going to amputate my leg and I may be able to picture myself without it but I cannot know what the experience will be like without some powerful frame of reference. This reference point can only exist when I'm actually immersed in the experience. Only after the actual event could I truly appreciate the consequences.

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[30] Buchanan and Brock, p. 24.
[31] Buchanan and Brock, p. 24.
[32] Buchanan and Brock, p. 24.

Buchanan and Brock do not spend a great deal of time discussing the issue of communication except to say that special efforts may be necessary to maximize the patient's capacity to understand and communicate. One is to do this by using simple words or alternative ways of presenting material and permit the patient to use non-linguistic forms of communication (such as the patient blinking his/her eyes for simple 'yes' and 'no' responses). However, the focus cannot be just upon the patient's ability to express his/her wishes to others. We must also pay attention to the patient's being able to receive and interpret expressions from others, since understanding can only occur after the gathering and processing of information. For this to be possible, one needs to include the "possession of various linguistic, conceptual and cognitive abilities necessary for receiving and comprehending the particular information relevant to the decision at hand."[33]

The ability to understand and the ability to communicate are different in that the former has a direct relation with a person's competency, whereas the latter is a more indirect but nevertheless relevant factor. I may be able to think clearly and appreciate the alternatives, yet not be able to communicate my desires to others because I lack the requisite motor skills. If I cannot communicate, then I cannot make my decisions known and so others will ultimately have to make the decisions for me. Nevertheless, this does not mean that I do not possess other faculties that permit me to make a rational decision. I might recognize that a certain procedure is in my best interests but not be able to communicate that information to you.

Unfortunately, while we should appreciate the profound distinction between a person's not being able to understand from his/her not being able to communicate, this distinction is irrelevant from a practical point of view. A competent patient who is unable to communicate is a patient whom we must treat as incompetent. We cannot act on someone's wishes if he/she is unable to communicate those wishes to us. One can only hope that the decisions that are made for the patient who is, for all practical purposes, incompetent, are what he/she would have wanted.

The capacity to communicate must truly work both ways. All parties need to be able to correctly interpret the other's utterances. Caregivers need to be trained to recognize meaningful signs. Hence, it is crucial that health care providers recognize that communication is a significant component of their dealings with the patient and that communication can be expressed in many ways other than verbally:

> The nonverbal is indeed the language of sensitivity. It is the age-old language of lovers, that sublime communication without words. It is the language of the content, a knowing smile, an exchanged glance that tells more - much, much more than words

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[33] Buchanan and Brock, p. 24.

> can ever say. It is the frown that makes one feel guilty; the silent anger that emits a tenseness so real that it can almost be touched. It is that obscure, yet emphatic meaning behind the silence that thunders its message. The nonverbal is so complicated that it can convey an entire attitude, yet so simple that when a head nods or shakes everyone understands. All human relationships involve meanings that are more than words, and the nonverbal exposes the truth in these relationships.[34]

The various forms of communication that may be exchanged by patients and their caregivers, regardless of whether they are verbally expressed in an open, direct and honest manner, or through tone of voice, body language or even posture, provide the parties with the opportunity to recognize that the other individual is not a mere *object* that is to be manipulated or unilaterally acted *upon*, but is a *subject that is due consideration and respect.*

We also note that the individuals are communicating at all opens the door to the possibility of developing understanding and with understanding mutual trust or, if trust is not possible, the recognition of that fact. Communication not only is an essential element of competency it is also an essential element in promoting good relations between providers and patients.[35]

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[34] Galloway, Charles "Nonverbal: The Language of Sensitivity," **Theory Into Practice**, Vol. X, No. 4, October 1971, p. 227.

[35] Garland Lewis writes:

> Communication is effective when rational judgments are facilitated. This applies both to individuals (and) groups. Rational judgments can be arrived at when meanings are shared and there is respect for each other's ideas. Communication is more accurate when there is free feedback between persons. When an individual feels free to ask questions, he arrives at a better understanding of what another is trying to communicate. There is more certainty and confidence developed if feedback is adequate. Communication is also more effective when nonverbal messages are recognized, acknowledged, and accurately interpreted. Communication that is non-threatening aids the

Buchanan and Brock's second condition, that competence requires capacities for reasoning and deliberation, should be readily acceptable. One needs to possess memory, make inferences, compare alternative outcomes, employ probabilistic or inductive reasoning, draw logical conclusions from the evidence considered and give due consideration to potential outcomes. These various capacities are then applied to a system of values. Accordingly, the authors maintain that a competent decision-maker also requires a set of values or conception of the good that is minimally consistent, stable and affirmed as his/her own.[36] One needs this set of values in order to evaluate particular outcomes as benefits or harms and to assign different relative weights to the outcomes. A fully consistent set of goals is not required because values can change over time and ambivalence is inevitable. However, sufficient stability is needed in order to permit, at the very least, a decision that can be stated and adhered to over the course of its discussion, deliberation and implementation.

Since it may strike some as odd that a set of inconsistent beliefs is in keeping with competency, we need to evaluate the suitability of consistency as a condition of competency. What is the connection between consistency and say, rationality, and between rationality and competency? Is consistency of beliefs sufficient to establish rationality?

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flow of information and conveys a sincere interest towards others, facilitating positive interactions. The real value of effective communication lies in its ability to increase understanding among men.

Lewis, Garland **Nurse-Patient Communication**, 2nd Ed., (Wm. C. Brown Company, Dubuque, Iowa: 1973), p. 11.

[36] Buchanan and Brock, p. 25.

The simple answer is "No", for consistency does not necessarily entail rationality and rational people need not always be consistent.

Although erratic behaviour may be signs of mental illness, mentally ill persons can act consistently and reason accordingly. For example, it would be consistent with the view that one is always being followed to take appropriate measures such as walking outdoors in disguise. Such individuals may not suffer from thought blocking, loose associations or tangential thinking and their thought processes can flow from one point to another in a logical manner, yet they suffer from a mental illness. If we were having an informal conversation with a paranoid schizophrenic, the only way we might distinguish him/her from a "normal" individual is that his/her cognitive processes are based on irrational and unfounded perceptions and beliefs. Consider the woman who claims: "I died 100 times last night". She responds to the question: "Then how can you be here today?" by stating: "God resurrected me each time".[37] While bizarre, it would be difficult to argue against her since her response is internally consistent with the rest of her beliefs. On the other side of the coin, rational individuals often hold inconsistent beliefs on the grounds that they are unsure about the issues and do not necessarily see the implications of their inconsistent beliefs. The person who is health conscious yet smokes and the politician who believes that killing is wrong in all circumstandes but favours capital punishment are examples of such individuals.

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[37] My thanks to David Vollick from the Department of Psychology, University College of the Cariboo, for this example.

Consider the case that I am asked to write out every belief that I have onto a classroom white board.[38] After many days of writing out specific beliefs (e.g., my name is..., I have 2 brothers, I will not win the lottery in the near future, etc.), general formulations for creating specific statements (e.g., one can create a larger number by adding 1 to the previous number) along with Aristotelian universals and variations, I may sincerely state that these statements represent all the propositions that I believe to be true. Yet, given the vast number of beliefs that I hold as true, it would also be rational to hold that some of the beliefs are actually false and, as well, that some of these beliefs are incompatible with others. I can adhere to this position without knowing which specific beliefs are in conflict. Hence, if one is truly rational, then one is put into a situation where one believes that all of one's beliefs are true (for one would not accept them otherwise), and one also believes that some of these beliefs are false. To do so is just to accept that we are fallible agents.

A person who is aware that his/her belief system has inconsistencies is probably a better candidate for being considered competent. A more fitting requirement for competency is not just the possession of minimally consistent beliefs and values but, rather, the possession of a preponderance of consistent beliefs that reasonably reflect the truth of the matter.[39] The ability to abstract and work through arguments in a rational manner also clearly plays some instrumental role in one's being competent. Reason tells us which acts are useful and prudential to achieve whatever our goals may be (rational or otherwise) but it does not follow from this that we will act in accordance with reason. We may have reasons to act but we must also have a desire to act and if we are indifferent about the end, then we may also be indifferent about the means to the end.

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[38] My thanks to Michael Stack from the Department of Philosophy, University of Manitoba for this particular example.

[39] 'The truth of the matter' is notably vague so that we don't need to get into epistemological discussions regarding which theory of truth is correct or into discussions of pragmatism or moral realism or any of a number of other related topics.

After making some minor revisions in Buchanan and Brock's theory of competence, there is something still lacking. Competency requires more than what they have offered us. If we were to ascertain whether I was competent, I must have the basic appreciation that when something is done to "Jeff" that "Jeff" refers to *me*. Self-awareness is essential to being able to fulfill one's own interests. I also wish to continue to modify the proposed "minimally consistent system of beliefs" because, as we've seen, consistency is not a sufficient source to establish competency. Instead, a more complete notion of a 'planned life' that is broader in scope is required. This 'planned life' includes some sense of foresight and the ability to adapt with the unexpected changes that one faces in life.

A competent individual's values are to stable or relatively permanent, but these values cannot be considered static since they can (and should) evolve with the influx of new insight and information. "Fore-sight", as the term is being used here, requires that one be able to place one's self in the future and imagine what it is like under various conditions. What one wants in the future (e.g., a spouse, a life of adventure, etc.) can motivate our present decisions to act. This notion is being used in a way that is in contrast with Nagel's position regarding our future interests as providing reasons for our present actions.[40] According to Nagel, we are to treat the future as being as real as the present, as well we are to give weight to those non-present desires.[41] One problem that this raises is how future desires provide us with present reasons since this seems to suggest reverse causality. Nagel counters that a person's future should be of interest to him not because it is among his present interests but it is his future but this position can only be made plausible if one sees Nagel as promoting an ambiguous notion of "future interests". The first sense of 'future interests' refers to those interests that one will have in the future and which will motivate one in the future (e.g., if and when a person becomes a parent, he/she will want to buy his/her children nice clothes). The second sense of 'future interests' is better referred to as "interests in the future" whereby one's present aims are to satisfy present interests which will culminate in the possible satisfaction of interests that were once in our future but are now in our present. (e.g., putting money into a registered pension). Accordingly, by adopting the latter move, a person can plan for his/her future now using only what interests he/she presently has for the future.

Permitting a flexible value system to account for changes in one's views or situation, as well as permitting inconsistent beliefs to be retained, fits well with the concepts of foresight and a planned life. This broader approach to one's value system provides not only the reason to act in accordance with one's own interests but also provides the companion elements and skills that are required. The ability to reflect upon one's position and to have self-knowledge is central to being competent.[42] Part of this ability involves the ability of abstract thought, to consider and reflect upon notions such as loss, gain, pain, pleasure, life, death, respect, humanity, care and love. This awareness involves personal knowledge as well as having a proper orientation with the world -- of knowing where one is in relation to the world around, knowing whether one is married or single, what year it is and so forth. Simple awareness of this information is not sufficient, as one requires *thoughtful* insight, that is, insight that allows one to perceive the ramifications of the choices that one makes. This insight also demands an aspect of objectivity so that we can make decisions that are best for us from a dispassionate perspective.

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[40] Nagel, Thomas **The Possibility of Altruism** (Clarendon Press, Oxford, 1970). Part Two.
[41] Nagel, Thomas **The Possibility of Altruism**. See his discussion on pp. 39-40.

Finally, then, to be a competent decision-maker whose choices are to be respected by others requires that the person possess the capacity for understanding, self-awareness, foresight and an intimate appreciation of his/her situation. As well, one must have "reason-ability" so that one promotes one's own relatively consistent subjective interests and values. We note that being unable to express this information to others affects one's competency to make decisions but it need not represent one's level of mental competency.

While people exhibit local competency in some areas and not in others, no matter what the context, competency itself ought not to be thought of as being a matter of degree. One is either competent in an area or one is not. This is established by looking at the function of competency in informed consent. Determination of competency places people into two groups: "those whose voluntary decisions must be respected and viewed as binding even if we personally disagree with their choices, and those whose decisions will be set aside."[43] Accordingly, Buchanan and Brock point out that the central purpose of assessing competency is to determine whether the patient retains the right to accept or refuse treatment or whether that right is to be handed over to a surrogate. In other words, the importance of accurately determining competency is the recognition of the patient's autonomy to choose.

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[42] I am using the term 'self-knowledge' instead of 'self-awareness' since the former suggests a greater understanding of oneself whereas the later connotes the experiential perception of oneself.

In exercising the right to give consent, competent patients usually decide in ways that they believe will best promote their own well being as they conceive it. However, as we have suggested, illness and its accompanying emotions of fear, anxiety and depression may have substantial impact on competent patients' abilities. Thus, what a patient chooses may fail to serve his/her own well being as he/she conceives it when he/she is temporarily affected by his/her illness. The promotion of a patient's well-being requires that we sometimes protect the individual from the harms that may result from his/her actions when the person is rendered incompetent. It is in such cases as clinical depression that pure paternalism is permissible but only as a temporary measure until such a time that the person regains competency. Accordingly, well-being supersedes autonomy in those cases where the patient reasons to certain ends that are radically inconsistent and out of character with his/her prior established interests, beliefs and values. Autonomy supersedes beneficence in those cases where the competent person makes an informed and reasoned decision regardless of our own personal opinions about the reasonableness of his/her decision.

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[43] Buchanan and Brock, p. 27.

If the other party (e.g., the physician) does not believe the decision made by the patient is a reasonable one, then he/she is equally permitted to exercise his/her autonomy and not support the decision so long as he/she does not interfere with the patient's liberty. A person who is about to jump off a cliff to meet certain death should be prevented from doing so because it allows us the opportunity to make sure that the individual is competent. If the individual is competent, then we must let him/her do as he/she so chooses regardless of the tragic results that might result.[44] Whereas, if the individual is not competent, then we should assist him/her in regaining his/her facilities and if he/she still wishes to jump then that is his/her right as a rational autonomous agent to perform whatever self-directed activity he/she chooses. The person who wants to commit suicide has provided us with *prima facie* grounds for evaluating his/her competency because he/she is attempting to harm (what we are referring to as) the objective interest of self-preservation. However, the person's apparent irrational action does not by itself provide us with grounds for labeling him/her incompetent. What is important is not the actual decision made but, rather, the process that was used to reach that decision. The competent person is to make a *reasoned* decision that may not necessarily be seen as a *reasonable* one. Due to the seriousness of the life-threatening action, we are right to *check* if the person is competent. However, we are not right to *assume* that based on their behaviour alone that they are incompetent. For example, it may be rational for a person to attempt to take his/her own life if he/she is suffering from terminal cancer and the current course of debilitating treatment will only marginally extend his/her life. By intervening when needed and releasing the suicidal person if they are assessed as competent, we have complied with both principles of benevolence and autonomy.

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[44] If the action will negatively impact or affect others (e.g., the suicide's children) then their interests may have to be weighed into the decision of whether or not to interfere.

A principle of autonomy allows us to make significant self-directed choices about our own lives, not just in terms of personal survival, but on the more philosophical level of living our lives as we best see fit. The dignity that a human being deserves is closely tied with his/her ability to act in ways that he/she wishes when such decisions are not adversely affecting the lives and aspirations of others. Liberty for the competent patient entails the freedom to choose and the freedom from intervention. To assist such individuals in this regard, we require that reasonable medical disclosure be made so that the competent person will have the grounds for making the best decision for himself/herself. However, if we recognize that individuals are locally competent in some areas (and not others) we must ensure that we don't adopt a monolithic approach to competency whereby a person is deemed competent if he/she possesses the relevant decision-making capacities no matter the complexity or level of risk of the decision.[45] This approach should be rejected on the grounds that it would permit the five-year-old child who is competent to not only select what he/she wants to eat but also allow him/her to reject life sustaining surgery. The risk is clearly greater in the second case so physicians should be more careful in their assessments of the patient's abilities. Likewise, since the issues in the second case are more difficult to grasp, the more information and understanding that is required by the patient. Thus, there is a greater onus upon the physician to ensure that the patient appreciates the situation, understands the information, and is competent to make the decision.

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[45] Buchanan and Brock, p. 49.

In low-risk but highly beneficial medical cases, the importance of the patient's insight and knowledge diminish. In such cases, it would not be a harmful idea to let mature-minors exercise some degree of control and make their own decisions. Clinical psychologist David Vollick notes that persons who suffer from a mental illness may be competent to consent to drug therapy but not to more extensive treatment.[46] Furthermore, Vollick comments that once the drug therapy has been effective, the patient may then be able to consent to the further treatment.

Consent to a procedure that is of low risk but of great benefit should require only a minimal level of competency (e.g., the patient should understand what they are consenting to) but refusal of that same procedure should probably require the highest level of competency (e.g., the patient should appreciate the personal consequences) The reason for this is that we would rightfully question whether the patient truly appreciates the implications of his/her decision. Furthermore, by adopting a decision-sensitive concept of competence, we allow for finding a person incompetent in regards to one particular decision without drastically changing the person's overall status as a decision-maker. Thus, we don't want to allow five-year-olds to be considered competent enough to consent or refuse major surgeries (and instead we rely on their parents or guardians), and we don't want persons who are unable to consent to complex treatments to be automatically denied the right to consent to minor ones. Inasmuch as a person is judged to be incompetent without specific reference to the context of the decision, medical paternalism will seep dangerously deep into all aspects of that person's life. Putting a blanket over the individual's ability to make decisions, no matter how minor, removes any sort of personal engagement that the patient may have had with the world -- including the potential and ability to change his/her place within it by means of entering contractual relationships.

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[46] Personal discussion, February, 24, 1998.

For any patient's choice, those responsible for deciding that it should be respected should have grounds for believing that the choice is in accordance with the patient's well-being. The effects of the decision upon a patient's well-being should be evaluated in terms of his/her own underlying and enduring aims and values so that the health care provider can acknowledge the possibility of disagreement and yet still abide by the decision. Nevertheless, it is important to accept that competent persons have the right to make foolish choices. So long as the choice is arrived at through a *reasoned* process, and an informed patient voluntarily and competently makes it, then it must be respected. When personal aims and values are not known, the individual's well being should be evaluated in terms of the long range effects on the particular objective interests that are relevant to the patient in question.

The relationship between well-being and autonomy creates a problem depending upon the degree or standard of competency imposed. If we have a strict or high standard of competence, then more people will be found incompetent.[47] Acting on this standard is done to minimize the failure to protect persons from their own poor decisions. However, this standard increases the incidence of intrusion and turning over the decision making process to a third party. On the other hand, if we have a low standard, then more people will be found competent and, thus, raise the incidence of poor decision making while minimizing the external interference. Buchanan and Brock comment that there is no correct way to assign relative weight to the values of self-determination and well-being and it may well be that it is a simple truth about our individuality that different people will assign these values different weights. Yet, if we accept this claim that people do in fact assign different importance to these principles, then the best policy would be one which allows competent people to have the liberty to assign their own weights. Accordingly, well-being is more important in cases when the person is not competent and autonomy is more important in cases where he/she is. It just so happens that it is an ironic turn of events that we sometimes limit a person's freedom in order to promote it. However, this irony is not contradictory in that the well-being of the person is being promoted when he/she is incompetent and his/her autonomy is being protected when he/she is competent.

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[47] Buchanan and Brock, p. 40.

Signed documents such as informed consent forms can represent the intent to contract so it is crucial that patients are able to appreciate the expressed and implied terms. As such, determining the capacity to contract is the first step towards assuming that the contract is voluntarily entered into. The autonomous person has the opportunity to make free choices. In order to be meaningful, these choices must be real options that are based on an accurate picture of the world as well as the patient's ability to have an accurate and reasonable point of view of this world. The greater the risks involved, the greater our need to be sure that the patient is able to understand and appreciate the complexities of his/her situation and that he/she gives informed consent.

Any standard of competency that can create situations where the patient does not have an adequate grasp of himself/herself and his/her world, and yet is permitted to exercise autonomy, is a standard of competency that is harmful to patients. On the other hand, a standard of competency that is too restrictive and imposes points of view other than those of the patients' (e.g., a standard that requires that reasonable decisions are made) is disrespectful to the dignity of the patient as a person. Accordingly, neither approach can be considered suitable for our account of a contractual theory of medical ethics. We need to avoid giving too much power to those who cannot wield it in their own favour, and we must allow those who are capable to wield power, the opportunity to do so.

Thus, the standard of competency that fits into the liberal communitarian contract theory is a modification of Buchanan and Brock's theory. It protects the vulnerable patient from being a victim of their own incompetence while allowing the capable patient latitude to act upon his/her own best interests based upon his/her own informed preferences without severe interference. This standard is more respectful of the necessary balance between self-determination and well-being. However, patient autonomy is not to be used as a trump card against the physician or against other parties. As we will see in the next chapter, a medical ethic that rightfully gives (or restores) power to the patient must still be situated within the broader scope of the interests of the community.

As Canadian taxpayers, we collectively pay the piper. Surely that gives us the right to choose what music he plays.
--Michael Rachlis & Carol Kushner, **Second Opinion**[1]

CHAPTER EIGHT

Contracts and Community Sensibilities

I. Introduction

Advances in modern medicine make it harder for the patient to know substantive information about his/her medical situation. This difficulty can adversely affect a person's ability to exercise his/her autonomy. Furthermore, the complexities of modern medicine can lead to greater discrepancies in the positions of the health care provider and the patient. Thus, given the direct involvement of the patient and the potential consequences of the actions that are taken on his/her behalf by health care providers, efforts must be made to rectify any inequities.

A *laissez-faire* framework is inadequate as a Canadian template since it remains overly individualistic and, thus, it is not applicable to a socialized approach to medical insurance. The *laissez-faire* approach also ignores and may even promote an unjust balance of contractual power as it reduces in both real and symbolic terms the egalitarian ideal of liberalism -- an ideal that lies behind our national system of health care. For persons who are disadvantaged (e.g., the poor, the ignorant), the concept of

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[1] Rachlis, M & Kushner, C. **Second Opinion: What's Wrong with Canada's Health-Care System**, (Toronto: Collins Publishers, 1989), p. 295.

"freedom of contract" can be viewed as an empty gesture. Those who cannot afford many of the costs associated with entering the arena consequently have little or no bargaining power. This state of affairs is a concern because of the importance of individual rights and so we aim to protect these rights from being unduly impeded either by the state or by market forces. Still, we have also seen the development of various governmental constraints and restrictions upon the freedom of contract which enforce regulatory measures to reduce the inequality between the contracting players. These measures take the forms of safety nets, competition, rules of disclosure etc., and are aimed at making the "game" a bit more even and a little less open-ended. The union of the liberal and communitarian elements in this thesis promotes a broadly conceived framework that is flexible enough to permit the "game" to continue smoothly, but which rightfully acknowledges the need for rules to be set in place in order to protect the common wealth of all the players. It is also for this reason of protecting all the players that we needed to introduce an appropriate standard of competence.

Reducing the gap between the provider and the patient is difficult. For if the liberal conceptions of contract lean towards individualism in terms of reducing the range of contractual responsibilities (especially for the contracting party who has the advantage), then we are led to a situation whereby the State sanctions (or at least turns a blind eye towards) a relationship that could victimize the vulnerable and allow parties free reign. Autonomy of the parties may be protected, but at what cost? Is autonomy truly protected for the individual who has no other choice but to accept any offer that is put on the table because he/she has no bargaining power or because he/she doesn't know any better? On the other hand, if altruistic (and paternalistic) considerations are pushed too far in re-aligning distributive justice (as Collins is apt to favour) then the enforceability of specific contracts is reduced substantially and the moral significance of persons voluntarily entering contracts is reduced. What has been stressed in the preceding pages is the need to strike a balance between these two positions that will level the competing interests of all those concerned. In the following, I shall try and provide justification and an explanation of some of the parameters that will help define the rights and duties of those involved in the physician-patient relationship. In doing so, it is hoped that the importance of community autonomy, individual autonomy and democratic process are recognized as being essential elements in re-addressing medical matters which can be rectified by an appeal to a contract theory of medical ethics.

II. Policies and Parameters of Health care Systems

Canadians are in a somewhat different position in terms of health care institutions and structures than their counterparts in the United States. The public sentiment attached to these institutions must be acknowledged as providing some evidence to support communitarian principles and values. Since Confederation in 1867, the role of the federal and provincial governments' responsibility with matters of health and illness has always been one of a partnership, an unequal and non-static partnership, but a partnership nevertheless.[2] The *Constitution Act, 1867 gave* primary responsibility of health issues to the provincial governments. In 1948, The Health Grants Program provided the first hints of a national insurance plan. The costs of this program, which was aimed at developing a variety of health care services,[3] were shared by the federal and provincial governments. In 1957, national hospital insurance was established and in 1966, federal funding for insured medical services was conditionally provided under the *Medical Care Act* in which the terms and conditions for federal government transfer payments to the provinces and territories were spelled out. These conditions were then changed to block funding under *The Federal-Provincial Fiscal Arrangements and Established Programs Financing Act, 1977.* A strong sense of community and the equality of persons within that community along with the more concrete governmental concerns about the conditions of transfer payments, user fees and extra billing, formed the groundswell which led to the 1984 *Canada Health Act*. The Health Act listed five criteria that had to be met in order for provinces to receive full funding. These criteria ensure that all Canadians have access to medically necessary services:

> Public administration: the health care insurance plan of a province must be administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province;

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[2] See "Health Care Policy in Canada", Nancy Miller Chenier, Library of Parliament, Research Branch, October 1993. As well, Bernard Dickens, David Roy and John Williams offer a nice short treatment of the historical elements of Canada's health care system in **Bioethics in Canada** (Scarborough: Prentice Hall Canada, 1994) pp.91-95.

[3] For example, providing training services for health care workers to deal with tuberculosis, cancer and mental illness as well as surveys of provincial health needs and the construction of hospitals.

> Comprehensiveness: the health care insurance plan of a province must insure all insured health care services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners;
> Universality: the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions;
> Portability: the health care insurance plan of a province (a) must not impose any minimum period of residence (in excess of three months), (b)...must provide for the payment of amounts for the cost of insured health services provided to insured persons while temporarily absent from the province, (c) ...must provide for the payment, during any minimum period of residence...of the cost of insured health services provided to persons who have ceased to be insured persons by reason of having become residents of that other province;
> Accessibility: the health care insurance plan of a province must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude...reasonable access to those services by insured persons.[4]

These criteria establish that an individual as a member of the community is guaranteed certain health care rights and the community has a responsibility to that individual. Accordingly, there must be strong grounds for suggesting that the interests of the individual are to be sacrificed for the interests of the community.

With a national health care system in place and in light of the public's demand for cost containment within a changing economic climate, we must strive towards a socially and economically sound policy that realistically aims toward a just conception of the private and public good. This concept incorporates private interests and rights as weighed against the acknowledged interests and responsibilities of the community. It should be noted that there is a ground swell towards this goal as even our American counterparts are more and more drawn to recognize the need of balancing social and personal interests when developing a health care program.[5] This is telling given the historical resistance by the American Medical Association (AMA) against government regulation that range from the AMA's opposition to direct government funding of medical education to their hostile battle against the introduction of Medicare and Medicaid in the 1960's.[6] Achieving the balance between social and personal interests will most likely mean bringing into existence a more cost-effective and appropriate distribution of health care resources that ensures medically necessary care while at the same time eliminating, reducing or privatizing certain medical costs. This can be enacted within the provider-patient contract that now recognizes that such contracts are not one-to-one relationships but ones that include the community as a third party.

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[4] Excerpts taken from *Canada Health Act, 1984*, c.6, s. 8-12.

At the outset of this work, it was stated that the issues that would be raised here are issues that revolve around the edges of life, since it is with the beginnings and endings of human life that medical care often plays its most critical, controversial and costly roles. With the advances of medical technology and with an aging population, members of the public, be they philosophers, health care providers, politicians or patients, all face the same questions: "When is enough, enough?", "When should we actively pursue and preserve life, and when should we let it go?", "When do we provide treatment and when do we refuse?", "What are the costs, what are the risks and, most importantly, what are the benefits to each citizen who is, or is potentially, a patient?" -- The answers to these questions will provide insight to what sorts of over-arching guidelines are needed to direct physicians and patients.

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[5] See "Autonomy and the Common Weal", by Marion Danis and Larry R. Churchill, *Hastings Center Report* (Jan-Feb., 1991); "Decisions at the End of Life: Guided by Communities of Patients" by Linda and Ezekiel Emanuel, *Hastings Center Report* (Sept-Oct., 1993); "Setting Health Care Priorities: Oregon's Next Steps" by Charles J. Dougherty, *Hastings Center Report* (May-June 1991).

[6] Moran and Wood write: "Their (American Doctors) opposition to the introduction of Medicare and Medicaid was so strong that the federal government in 1965 in effect accepted unregulated fees by a political agreement enabling physicians to continue to bill the federal and state authorities, charging what were their 'usual, customary and prevailing' fee levels." Michael Moran, Bruce Wood, **States, Regulation and the Medical Profession**, (Open University Press: Buckingham England, 1993) p. 80.

The costs of caring at the edges of life are numerous. These costs include the burdens placed on the individual physician and his/her profession's ability to act, while acknowledging the inherent rights and objective interests of patients. These costs also include the physical, psychological and emotional strains put upon the patients and their families who are faced with life and death situations and decisions. There are also the costs which are exacted upon the community which encompass the perceived symbolic harm of having certain medical policies in place that deny patients treatments that they believe to be in their best interests even though medical evidence is to the contrary. Finally, there are the ever-escalating financial costs of the technology.

Accordingly, we need to try and resolve some of these costs while trying to decide policy matters regarding what medical treatments are to be provided by the community to competent and incompetent patients. As well, we need to determine when the physician's obligation shifts from respecting patient's rights and duties to protecting the community's interests. The issues of futile treatment, cost containment and *in vitro* fertilization will assist us in this task.[7]

III. Futility

As Griener has noted[8], a standard approach to the issue of futility asserts that certain forms of medical treatment are futile to use on certain patients, and therefore, physicians are not obligated to provide or perhaps even disclose information about such treatments. This is significant since it entails that futile treatment may be a topic that is not open for discussion at the physician-patient level, or if it is discussed, it is only after a decision has been made by the physician to not provide it. Accordingly, such a restriction would appear to infringe upon the freedom of the parties to determine the extent of their relationship.

For our purposes, we must be clear that if the treatment it is to be considered futile then the physician is *not duty bound* to offer it. In fact, for reasons that will be expanded upon momentarily, if the treatment is futile, then the physician is *duty bound not* to offer. Futile treatment should not be merely "optional" or "permissible", rather it should be viewed as "prohibited". Accordingly, it will be argued that a "no futile treatment" rule fits into the liberal communitarian contract of medical ethics as it is a reasonable limit to impose on the provider-patient relationship. Physicians should not be able to offer futile treatment and patients should not be able to demand it. So, then the obvious first question to ask is: What do we mean by "futile treatment"?

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[7] See: John D. Lantos *et al*, "The Illusion of Futility in Clinical Practice" *The American Journal of Medicine* (July 1989). 87, pp. 81-84; Lawrence J Schneiderman, Nancy S. Jecker and Albert R. Jonsen "Medical Futility: Its Meaning and Ethical Implications" *Annals of Internal Medicine*, (June 15, 1990) Vol. 112 No. 12, pp. 949-954; Tom Tomlinson, Howard Brody "Futility and the Ethics of Resuscitation" *Journal of the American Medical Association* (Sept. 12, 1990), Vol. 264., No. 10, pp. 1276-1280; Tom Tomlinson, Howard Brody "Ethics and Communication in Do-Not-Resuscitate Orders" *The New England Journal of Medicine* (Jan. 1, 1988), Vol. 318, No. 1., pp. 43-46; Robert Veatch, Carol Mason Spicer "Medically Futile Care: The Role of the Physician in Setting Limits" *American Journal of Law and Medicine* (1992), Vol. XVIII, Nos. 1 & 2, pp. 15-36.

[8] See Glenn Griener, "The Physician's Authority to Withhold Treatment" *The Journal of Medicine and Philosophy* 20:207-224, 1995.

Part of the difficulty surrounding futile treatment and whether it should be made available is due to conceptual confusion surrounding the notion of "futility". Most words in the English language are multi-vocal (i.e., have more than one meaning) and "futility" is no exception. What is considered futile to one person may not be futile to another. What is futile to the physician may not be futile to the patient who is grasping at any straw that may pull him/her back from the abyss. Disagreements about what should be considered futile are due, in part, to the fact that each person may be using the term differently. Accordingly, physicians and patients may be talking at "cross purposes", that is, using the same term but meaning different things by it. The physician may be focussed only on medical issues while the patient is concerned about a variety of personal issues.

Futile treatment is treatment that provides no benefit to the patient. By beneficial treatment we do not mean doing whatever the patient wants since he/she may have unrealistic expectations. Beneficial treatment is not merely prolonging the life of the patient since it may prolong a life that is not worth living. As well, it should not simply be considered to be treatment that has an effect on a patient since treatments can have an effect or can cause a change in the patient but not necessarily improve his/her condition or well-being. Beneficial treatment helps, assists or improves a patient's medical condition. Accordingly, futile treatment does not help, assist or improve the patient's medical condition.

To complicate matters even more, futile treatment may be "physiologically futile" and yet not "qualitatively futile". Medical treatment is physiologically futile if it has a very low probability of improving the physiological functions of the patient. "Qualitative futility" refers not so much to the sort of treatment that is applied, but rather it is an evaluation of the aim of the treatment in terms of affecting or improving the chances or probability of the patient attaining some worthy goal. Accordingly, the former may improve the chance of patient survival but the latter would look at whether that survival is a worthy goal.

In the eyes of many seriously ill patients and their guardians, some treatments may be physiologically futile, but not qualitatively futile. What may be considered in the best medical interests of the patient is not equivalent to, nor necessarily compatible with, the subjective interests of the patient. Accordingly, if physicians inform their patients that they are not going to try to save them "at all costs" because they believe it would only extend the patient's suffering or would only prolong the dying process, patients may reply that only they are able to judge whether the suffering is futile or whether their interests are worthy. From the perspective of dying patients, the treatment may not be futile treatment or "merely prolonging the dying process" if it means that they will be able to wrap up their affairs, permits them to adhere to their religious convictions or promotes their subjective interests in any way. Hence, although the recognition of a difference between physiological and qualitative futility may help clarify the case of when a patient and physicians are arguing at cross-purposes, it does not resolve the potential for physician and patient conflict.

Although qualitative futility is clearly value-laden, "physiological futility" is an elusive notion that, *prima facie*, appears value-free. However, it too is open to interpretation. How low must the probability of success be in order to consider the treatment futile: 10%?, 5%?, 3%? Physiological futility is, in fact, a normative concept and not an objective one since one physician may judge that a 10% success rate is unacceptably low while to another it may seem a long shot, but would still be something to offer to the patient. As well, if there are emotional factors involved in the case then these too may play role in determining if the level of probability is too low to attempt treatment. For example, one could imagine a physician attempting a procedure on a young child *because* there is a remote chance of success, whereas if the patient were elderly the procedure might *not* be attempted for the very same reason.

Truogg, Brett and Frader, in expressing their concerns regarding whether "physiologic futility" can serve as a value-free guide for physicians, point out that even if physicians could agree on a statistical cut-off point for determining futility, physicians are often highly unreliable in estimating the likelihood of the success of a therapeutic intervention.[9] Moreover, in theory, statistical inferences about what *might* happen to groups of patients do not permit accurate predictions of what *will* happen to the next such patient.[10]

It is not just a question of the statistical probability of the success of the treatment or intervention, as there is a discrepancy between what various physicians (and patients) take "success" to mean. For example, "success" cannot simply be interpreted as meaning "stability of vital functions" since this would be satisfied by PVS patients whose functions may be stabilized indefinitely.[11] Does success mean "complete recovery" or "reasonable recovery" and for what duration? For example, must the patient be discharged from the hospital and alive six months later in order for the treatment to be considered a complete or reasonable success? Furthermore, depending on how broadly or narrowly one conceives of the notion of "success", this conception will affect the perceived rates of success and thus poison the statistical data pool. For example, a successful treatment might mean that a patient fully recovers to the level or quality of health he/she had before sustaining the injury or disease. If so, then entire classes of medical treatments will have an extremely low rate of success and, accordingly, may be (inappropriately) considered to be "futile treatments" (e.g., many cancer treatments). If, for example, success is measured in terms of the patient's being alive and semi-lucid for 24 hours, then clearly the rates of success will be higher for some treatments than if success meant surviving to hospital discharge.

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[9] Robert Truogg, Allan Brett, and Joel Frader, "The Problem of Futility", *The New England Journal of Medicine* Vol. 326, No. 23, p. 1561.

[10] Truogg, Brett and Frader, p. 1561. Their "problem of futility" is based upon the problem of induction.

[11] In addition, merely stabilizing the patient opens the door for families to have unrealistic expectations of recovery.

It is a difficult issue to decide what would count as an acceptable use of the term "success" and it would not be inappropriate to turn to the community for guidance on this matter. Schneiderman and Jecker conclude a similar discussion of the issue by commenting that "the medical community and society at large must critically reflect upon...these explicitly defined notions -escape from dependence on intensive care or discharge from the hospital (and others too, perhaps) - and decide which one (or perhaps more than one) specific outcome measure represents a legitimate goal of medicine."[12] What is important perhaps, is not so much what is meant by "success" but that everyone in the community understands the definition and uses same standard when making evaluations.

However we define "success", we still must respond to the concern raised by Truogg *et al* that statistical inferences about what might happen to patients in certain circumstances does not tell us what will happen to a particular patient in the future. This is an example of the classic problem of induction. However, the demand for medical certainty requires one to set one's sights unreasonably high. In medicine, there can be no guarantees of what will or will not work for a particular patient. Even though “miraculous cures” do happen, we cannot base treatment guidelines upon what amounts to mere logical possibility. Yet, to demand that a class of treatments be considered futile only when they are, without question, non-beneficial is misguided since it is the nature of unexpected recoveries that they cannot be factored into our reasoning. We should not use the remote possibility of miracles as an excuse to evade making the hard decisions.

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[12] Schneiderman, L.J., & Jecker, N. **Wrong Medicine** (Baltimore: Johns Hopkins University Press, 1995) p. 162.

Physicians may be qualified to know what is best in terms of physiologically benefiting the patient and what the probability of success is for various treatments but without good communication they will not know what will benefit the various interests of the whole person. To allow a physician unilateral control to make decisions based upon his/her own views regarding quality of life without consideration of the competent patient's own perceived interests amounts to unjust medical paternalism. It is in instances where patients can actively participate in the decision-making process that can cause some physicians to be concerned that the resulting decisions will not be the best decisions. Yet since qualitative issues are subjective, patients should have some control over these issues if in fact it has been determined that medically unsound or inappropriate treatment will not be administered. For example, a patient should be able to voice a request to see a family member before one dies and the physician should comply, if possible, even if it means applying treatment that will extend the patient's life by a few hours or days.[13] As evidenced by this example, not administering treatment that is physiologically futile should not be a signal to health care providers to abandon the patient. The physician should not stop caring for, and about, the patient as a person. Even though it may be impossible (and inappropriate) to meet the medical needs of the patient, he/she has other interests that can be promoted including spiritual, emotion and physical comforts.

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[13] Even though they believe that physicians should refrain from administering futile treatment, Schneiderman and Jecker write: "The physician can easily make a compassionate exception in the case of a severely burned patient or mestastic cancer patient whose request for treatment will result in a small extension of life." P. 166.

If we have some rough but common-sensical understanding of what futile treatment is, namely that it does not help, assist or improve the medical condition of the patient, we need to argue why futile treatment should not be permitted. Patients might argue that since "low probability of success" does not mean "no probability of success", then they should have the right to gamble against the odds.

There are many reasons for why futile treatment should be restricted. Some of these are for empirical medical reasons, others are because such treatment has a negative effect on the community and the role of the medical profession. When the activities associated with a person's exercising autonomy harms another, (e.g., taking another's property without gaining permission), then there may be just cause for outside intervention, which places constraints on the activities. For example, **The Canadian Charter of Rights and Freedoms** recognizes that citizens have a right to "life, liberty and security of the person", but that these rights may be justifiably limited.[14] Although Canadians are the consumers of health care, as individuals they are not solely responsible for bearing all the direct costs of the treatments that they receive. Hence, the economic costs resulting from an individual patient receiving treatment indirectly affects the medical options that are available to others. Any treatment will drain financial and medical resources such that the treatment has the potential to affect the well-being of others.

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[14] Such was the argument for rejecting Sue Rodriquez's appeal for the right to assisted suicide: "The prohibition in s. 241 (b), which is a sufficient interaction with the justice system to engage the provisions of s. 7, (that everyone has the right to life, liberty and the security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice) deprives the appellant of autonomy over her person and causes her physical pain and psychological stress in a manner which impinges on the security of her person. Any resulting deprivation, however, is not contrary to the principles of fundamental justice...The respect for

Since the community is, in part, responsible for providing and paying for medical services, and has morally legitimate grounds for being involved in the development of the code of ethics that govern the physician-patient relationship, the community has a strong claim to demand the establishment of medical treatment guidelines.

The cost of treatment cannot be looked upon in isolation but must be reviewed within a larger context. Costs need to be considered in conjunction with the probable success of the treatment, the benefits of the treatment on the patient and the potential benefits for others if the funds went elsewhere.

The impact upon the community can be measured in more than just economic terms. There are strong philosophical concerns surrounding the impact of medically futile treatment upon the family and the medical profession which warrant limiting some patient-centered decisions. Futile treatment should be frowned upon because it promotes the misconception that 'everything is possible'. It does little but suggest that the physician

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human dignity, while one of the underlying principles upon which our society is based, is not a principle of fundamental justice within the meaning of s.7" *Rodriquez v. British Columbia* Supreme Court of Canada 1993 will attempt to do anything and everything regardless of its effectiveness. This perpetuates the public perception that physicians like to play God. Moreover, if everything *can* be done, then the family might argue that everything *should* be done. Thus, if the physician does not attempt to treat, he/she will be seen as not fulfilling his/her obligation to the patient. Surely, this is a quick way to destroy the integrity of the profession.

Physicians are within their rights to refuse to intervene and may also be morally wrong if they comply with the patient's request for futile treatment. Following a patient's request for medically futile treatment imposes a patient-centered, consumer-driven ethic upon the physician-patient relationship. Such an approach fails to recognize the costs that this attempt at promoting individual autonomy has on the immediate community. Since the treatment is of no benefit, then it does not promote the patient's well-being and it may in fact cause the patient to suffer more. Thus, the application of futile treatment has the potential to go against the physician's professional duty to help and not harm his/her patient. As well, since the life of the patient is not extended (or it is extended but the patient is incapacitated), then the treatment does not increase the opportunity for future acts of autonomy. Accordingly, an argument that a patient should be able to act autonomously and request futile treatment seems odd at best.

Scheiderman and Jecker wish to balance the patient's autonomy with the professional integrity of the physician and with the costs to society since the impact of futile treatment on the various parties who are directly or indirectly involved should be given due consideration. According to

Scheiderman and Jecker, patients can accept or refuse treatment but their demands must be qualified within the context of family and community needs and interests.[15] As such, patients should not be permitted to contract for futile treatment. Schneiderman and Jecker argue that it does not benefit the patient or his/her family or the physician or the community to permit medically ineffective treatment to be applied.[16] Furthermore, we note that by extending the dying process, or by performing ineffective procedures that some would describe as undignified, futile treatment forces family members to continue to deal with enormous amounts of emotional and psychological strain to no good end. The prognosis for the patient remains unchanged and the family's grief would simply be extended by a few hours or days.

If the application of futile treatment is permissible for the physician, it becomes individualistic and may, or may not, be applied to patients depending upon the particular physician and his/her attitudes and beliefs. Schneiderman and Jecker offer that without a strong uniform standard in place, physicians may define it to mean whatever they wish.[17] Medical intervention or the lack thereof, may be used by some physicians against the mentally ill, or by individual administrators as a cost-containment measure.[18] Accordingly, we can conclude that this uncertainty of treatment is something that is not in the best interests of any patient. Indeed, we can also point out that it would serve the patient's interest to know beforehand what medical situations may arise and how the provider will respond to them. With this awareness a patient may have a greater opportunity to exercise his/her autonomy because he/she knows what options will or will not be available. At the least, this information will allow the patient develop trust in the process instead of fear of the uncertainty of what the individual physician will do.

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[15] Schneiderman & Jecker, p. 37.

[16] Schneiderman & Jecker, pp. 35-50.

[17] Schneiderman & Jecker, p. 104.

[18] Schneiderman & Jecker, p. 104.

Scheiderman and Jecker also argue in favour of requiring physicians to refrain from offering futile treatment on the grounds that the public looks to medical practitioners to set standards for appropriate medical treatment. The profession receives the public trust to act in accordance with the best interests of the patient and "leaving the standard for beneficial and non-beneficial medical practice to individual clinicians abdicates the medical profession's responsibility to society."[19]

Schneiderman, Jecker and Jonson agree that if there is a low probability of medical benefit (e.g., a positive change in the patient's vital signs), then a unilateral decision by the physician to remove or withhold treatment is acceptable.[20] In matters of quality of life, Schneiderman, Jecker and Jonson opt for the traditional "physicians know best" approach and maintain that it is permissible for the physician to make a unilateral decision. Here, the physician considers what sorts of treatments are reasonable and only then discusses those alternatives with the patient. This, it is claimed, is common practice and is nothing new.[21] Accordingly, physicians should be allowed to determine futility in situations where keeping the patient alive would not be of qualitative benefit to him/her (e.g., patients who are in a permanent vegetative state). In fact, if we recall our previous discussion in chapter seven regarding consent and disclosure we see that this holds true. Physicians need only disclose information that is relevant to the patient's situation and since futile treatment does not offer any benefit to the patient, it is not relevant, and hence, there is no reason for disclosing it.

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[19] Schneiderman & Jecker, p. 105.

[20] Lawrence J. Schneiderman, Nancy S. Jecker, and Albert R. Jonson "Medical Futility: Its Meaning and Ethical Implications" *Annals of Internal Medicine*, June 15, 1990 Vol. 112 No. 12, pp. 949-954.

[21] Schneiderman, Jecker and Jonson, p. 951.

> ...It would be a mistake to create an exchange which in effect has the physician stating to the patient: "CPR would be of no use in treating your disease at this point. Do you want us to us it?" As other medical ethicists have pointed out, such a communication sends a meaningless, even contradictory, message which leads to confusion and distrust in the patient.[22]

If futile treatment prolongs a patient's suffering, and if suffering is a harm, then competent patients will not want to be subject to such medical interventions. Still, we must acknowledge the possibility that some patients may demand medical interventions that will almost certainly produce no net physiological benefit on the off chance that they may somehow "beat the odds". Again, one can go some distance to resolve this difficulty by establishing a contract based community standard that might, for example, emphasize the potential for benefit against the likelihood of achieving that benefit: The greater the benefit, the greater the grounds for treatment; the lower the success rate of the treatment, the greater the need to limit it.

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[22] Schniederman & Jecker, p. 165. The other medical ethicists that they refer to are T. Tomlinson and H. Brody, "Futility and the Ethics of Resuscitation," *JAMA* 264, no. 10, 1990 pp. 1276-80.

One such attempt at developing an appropriate policy on medical futility is put forward by Halevy and Brody. Halevy and Brody argue for a multi-institution collaborative policy on medical futility. This policy looks for institutions to agree upon the conditions of when to accept or refuse intra-institutional transfers of the care of patients.[23] It requires the physician to discuss the decision to withhold "inappropriate intervention" with the patient, *after* the physician has made the decision. If the parties cannot agree, then the case must be presented to an institutional body for review. Finally, if the institutional body agrees with the physician, medically inappropriate intervention may be terminated. The authors further assert that the institution may wish to substitute the phrase "may be terminated" with "must be terminated" even though the agreement of the patient (or surrogate decision-maker) has not been obtained.[24] Halevy and Brody's policy is a reaction to those potential circumstances when patient autonomy conflicts with professional integrity. However, since the treatment is unwarranted then the conflict should be mitigated. Accordingly, Halevy and Brody's policy goes a long way as an attempt at developing community understanding of what procedures will, and should, be enacted. With the clarification of the concept of futile treatment we can reassure patients that they will not be victimized by a community-based tyranny that sets standards that are incompatible with acts that promote the patient's best interests. By withholding such treatment, the patient's relevant interests are not harmed. It follows then, that these interests are not being sacrificed in the name of promoting the interests of the community.

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[23] Amir Halevy and Baruch Brody, "A Multi-institution Collaborative Policy on Medical Futility" *Journal of the American Medical Association*, August 21, 1996 Vol. 276, No. 7.

[24] Halevy, Brody, p. 573.

One might argue that if we have guidelines that justify physicians withholding medically futile treatment, these guidelines might also be used to remove that decision-making power from physicians and place it in the hands of others. Glenn Griener is interested in the issue of handing over this decision-making control from doctors to administrators. [25] This sort of situation would be unsatisfactory since administrators are not only removed from the immediate medical situation but are also not motivated by the same factors and indicators as the physician or patient since they also bring to the equation the institution's bottom line. Griener's concern is a significant one and thus provides further impetus for finding a more palatable community-based option. By handing the power over to the community in ways that mirror direct democracy via public town hall meetings, information groups and even judicial review, the decision-making will (albeit in a modified form) be in the hands of the members of the community who are most directly involved: the medical profession and its potential patients.

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[25] See Glenn Griener, "The Physician's Authority to Withhold Treatment" *The Journal of Medicine and Philosophy* 20:207-224, 1995.

IV. Other Costs and Community Concerns.

The ethical basis for a "no futile treatment rule" can be generalized to cover imposing other limitations on the provider-patient relationship. The contractual constraints that should be placed on physician-patient relationships will represent two over-arching ethical principles. First, a sense of limited autonomy is needed since patients have the right to accept or refuse treatment but should not be permitted access to unnecessary or useless (and potentially harmful) treatments. The restriction on what the patient may request is also a response to the significant interests of others including the professional interests of the physician. However, the interests of others (e.g., family members) may be overridden in cases where the health and life of the patient is at risk. Second, a guarded use of beneficence is required since some patients are incompetent and thus cannot fully participate in the decision-making process.

Given that there are least two parties who are either willingly or out of necessity directly involved in the physician-patient relationship, it would be inappropriate to automatically disregard all the possible subjective and objective interests of one party in favor of the other. If we hand complete control over to the physician in the name of adhering to a guiding principle of beneficence, we run the risk of raising questions about the legitimacy of the physician-centered ethics and medical paternalism, as well as the difficulties of accessing the best interest of patients. On the other hand, if we go to the other extreme and adopt a medical ethic that is based solely upon a broadly construed principle of autonomy (e.g. one that mimics a *laissez-faire* approach), then patients will be in the position to demand of their health care system things that the community cannot reasonably and ethically, provide.

If patients are not provided with some restrictions in terms of the type of care and medical treatment that they can request, then we are committed to maintaining that their subjective interests are considered to be sovereign. We will be conceding that patients not only have the liberty to accept or refuse medical treatment but also have the right to *demand* that others provide them with all and any medical treatments no matter how costly or medically unwarranted. For example, if individuals have claim rights to assisted suicide, then the conditions in which this issue has been traditionally portrayed may be too restrictive. That is, if one has a claim right to assisted suicide, it creates a reciprocal duty on others and it may be the case that suicidal individuals could be assisted in their quest even if they are not terminally ill or suffering severely. They may request and receive assistance simply on the grounds that they have concluded that suicide is in their subjective interest. Of course, if an individual requests suicide assistance and he/she is not suffering or terminally ill, then there is good reason to suspect that he/she is incompetent and, if so, the request may be rightfully denied.[26],[27]

The desire for a medical ethic based on the patient's rights movement is understandable as a reaction to a health care system that views medical treatment as a consumer good that can be bought and sold within a capitalist marketplace. This is understandable because the act of offering funds for a medical service which is accepted by the physician, creates a reciprocal duty upon the physician to provide the goods and services agreed to in just the same way that an acceptance of cash or a promise of cash provides a duty upon a shopkeeper to provide the sale goods which the customer offered to purchase. Within this sort of open-ended framework, if the patient/consumer desires for and can pay for what would be considered futile treatment and no other parties are adversely affected, I see no immediate reason why we should deny health care providers the liberty to satisfy this patient's request if the provider is freely and legally entering the contract. Yet, since it is not just the patient who is incurring direct financial obligations, such an open-ended and individualistic approach is unacceptable in a single-payer, universal-coverage system (such as Canada's or the compulsory insurance system of Germany).[28] Thus, objections that are raised against the individualistic approach to contract are suitable within the Canadian atmosphere for at least three reasons.

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[26] Daniel Callahan had expressed similar views in "When Self-Determination Run Amok", *Hastings Center Reports* 22 (March/April) 1994, pp.52-55.

[27] This transaction may be viewed as one in which the individual has requested to be 'murdered'.

First, we have argued how communitarian influences can and have affected the freedom of contract and that such influences are generally positive. Second, the Canadian health care system is a single-payer system so it is not simply the consumer of care but rather all the tax paying members of the community who ultimately reimburse the health care providers and institutions for their services. Our third reason is related to the first two. The right to autonomy cannot be exercised absolutely since the actions that a person takes can have a detrimental effect upon others. Exercising your right to autonomy may unfairly affect my ability to exercise my right to autonomy. The classic example of this is when a person attempts to exercise their autonomy by killing another person. This results in the violation of the victim's right not to be killed. However, a more relevant example involves the individual who receives an undue share of the medical resources that could have gone towards providing medical assistance for another individual directly, by giving the second party the medical treatment intended for the first, or indirectly, by diverting financial resources, time and medical attention to the second party. The appropriation of health care treatments that are "undue" includes such things as futile treatment and unproven treatments.

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[28] Moran, M., Wood, B., **States, Regulation and the Medical Profession**, (Open University Press: Buckingham, England, 1993) , pp. 7-15. In Germany, most medical care is free. Citizens must have insurance, which is provided by various health insurance funds that they pay in to.

By introducing guidelines concerning what is medically, ethically and economically mandatory, permissible or prohibited, the community is thus able to thwart the unbridled and inappropriate consumerism that is mistakenly associated with contract theories. As well, the community upholds the common good that is associated with autonomy and beneficence. By placing broad restrictions on the choices made by the patient or by putting limits on what the physician can or cannot do, we remove some of the need for distinct and separate rules for competent and incompetent patients (e.g., it is not the case that the competent patient can receive a particular treatment whereas the incompetent patient in the same position is denied). Accordingly, these steps are aimed at promoted the interests of all parties rather than sacrificing the rights of one for the protection of another.

With standards and guidelines in place the parties (or their representatives) are able to contract in a non-threatening, and reasonably stable, environment. Furthermore, since the focus of the guidelines is primarily upon the treatment and the process of decision making, and not upon the value judgments associated with the competency or incompetency of the patient, there will be some overlap of what sorts of patients are involved. As such, the process of medical delivery is further streamlined.

One of the most talked about examples of streamlining health care is *The Oregon Basic Health Services Act*, which prioritizes the health services of Oregonians. Part of the Health Services Commission's work was to obtain community participation to learn what Oregonians value most about health and health care as well as to develop objective measures "to assess the relative costs, benefits and importance of health care services".[29]

The Oregon Basic Health Services Act involved four steps. First, to develop a list of health service priorities based on community values, on technical information regarding the health services and needs of the public. The values which included quality of life and cost effectiveness, were arranged under three broad headings: *value to society*, *value to an individual at risk of needing the service*, and *essential to a basic health care package*.[30] These groupings were established through a series of public hearings, community meetings and a telephone survey. The effectiveness of services and treatments were determined by various special groups of experts. The second step was for the full legislature to set the budget of the new health care plan using the information gathered in the first step. Although the Oregon legislature was presented with a list of 709 "condition-treatment pairs" to fund, they voted to expand the Medicaid program to cover funding of the list up to and including line item 587. Step three involved the various agencies setting up their programs. Step four was the implementation of the programs in the community.[31]

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[29] *Oregon Basic Health Services Program* (Oregon. Office of Medical Assistance Programs) Feb. 22, 1991, cited in: Charles Dougherty's Conference Report: "Setting Health Care Priorities: Oregon's Next Steps", *Hastings Center Report*, May-June 1991.

The introduction of such cost considerations into ethical issues is considered by some to be implausible and/or inappropriate.[32] However, the reality of economic forces serves as important philosophical and practical purpose in setting limits as to the extent to which patients and physicians can freely interact. Cost containment must be recognized for what it is: a real world limitation that is imposed upon what services physicians can offer and what services patients can request.

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[30] "Value to society (is) defined as comprising the values of prevention, benefit to many, impact on society, quality of life impact, personal responsibility, cost-effectiveness, community compassion, and response to mental health and chemical dependency problems; values to an individual at risk of needing the service (is) defined as comprising the values of prevention, quality of life, ability to function, length of life, personal responsibility, equity, effectiveness of treatment, personal choice, community compassion, and the response to mental health and chemical dependency problems; and essential to a basic health care package (is) defined as comprising the values of prevention, benefit to many, quality of life impact, cost-effectiveness, and impact on society." Michael Garland, "Rationing in Public: Oregon's Priority-Setting Methodology", in Strosberg, M., Wiener, J, Baker, R. & Fein, A. (Ed). **Rationing America's Medical Care: The Oregon Plan and Beyond,** (The Brookings Institution: Washington D.C., 1992) p. 47.

[31] Michael Garland, "Rationing in Public: Oregon's Priority-Setting Methodology", in Strosberg, M., Wiener, J, Baker, R. & Fein, A. (Ed). **Rationing America's Medical Care: The Oregon Plan and Beyond,** (The Brookings Institution: Washington D.C., 1992). pp. 37-59.

V. Economics and the Commodification of Patients

Applied ethics often involves comparing "what is the case" with "what ought to be the case". Still, what "ought to be the case" must be grounded in the realities of everyday life. If we had unlimited medical resources, unlimited funds and an unlimited number of physicians to care for patients, then many of the questions that are raised in this last chapter would be moot. However, since we are applying ethics to the real world, economic factors force us to revise our stated goal from "What ought to be the case?" to "What ought to be the case given what we can do?" Of course, none of this is to deny that utopian ideals provide us with a direction to strive towards since any goal that is obtainable is probably a goal that was set too low.

One reason why people do not like to see connections made between economics and ethics is that people react with distaste when the talk around the table turns to talk about putting a price on human life (something that many believe to be an outlandish claim). Nevertheless, this worry is unfounded since the commodification of human life is not in conflict with the respect and dignity that all human life warrants.

Economic theory parallels tort law in terms of the latter compensating for such things as wrongful death and for fetal harms. For example, the mother can sue on behalf of the fetus if the fetus is damaged as a result of a harm incurred upon her (e.g., if she falls while exiting a bus because the driver pulled away too soon). Clearly, any sort of payment might be seen as quantifying life and, therefore, denying the respect and dignity of the individual as it "puts a price tag on something that is priceless." However, compensation for a life and the value of that life is not the same thing. A plane crashes because of mechanical failure and compensation is paid. However, this compensation is not for the life lost, but rather it is for the lost opportunities and lost wages that the person would have enjoyed if he/she was alive or if he/she was not injured. Giving compensation for lost opportunities and lost wages is an admission that the life or the limb lost is irreplaceable but that some sort of recompense is due to the survivor (or the surviving families).

Although the above may offer limited reassurance to some, the next point will mostly likely not. Many products that we purchase have built-in costs that are created by the need to enhance the safety of the product. Automobile companies, in designing their products, take into consideration the number of lives that will be saved if certain safety features are incorporated into the product. The greater the cost, the more justification it will require. Would the average consumer be willing to pay an extra $10,000 per car if it meant a marginal increase in the car's safety? Some may and some may not, but many would simply be unable to own a car since the price of the automobile would be beyond their means.

In a socialized system of health care where all the members of the community share in the benefits of the system and most (i.e., taxpayers) share in the costs that come with universalized medical insurance, we cannot give everyone what they desire and unfortunately we cannot give everyone what they need. When we put our money into certain areas of care, we are taking it away from some other areas. Accordingly, a policy of "anything for anyone" is unrealistic. How well (that is, how efficiently) our health care funds are being utilized can only be measured in outcomes: How many lives would be saved if we had more magnetic resonance imaging (MRI) machines versus more dialysis machines? How many lives would be saved or benefited if we had more pre-natal intensive care units versus better pre-natal education? Placing a price tag on life is of instrumental necessity in distributing our finite medical resources. By determining what is possible and what is most effective, we can promote the value we place on human life.

The State is made up of a variety of communities that, in turn, are made up of individuals who can share similar or overlapping aims and values. As a collective, the community needs to determine what medical procedures will be funded. In some real sense the community, like its members, needs limited autonomy from the State, as the make-up of each community will differ slightly in terms of social, political, geographical, economic and religious influences. Accordingly, the needs of each community will also differ slightly. The community, as we have argued, is, in essence, the third party of the contract. The community must also be involved in the process of determining the range of health care options open to its members. The development of an appropriate and publicly supportable process is a complex and difficult challenge, for as Kaplan notes:

> The most important challenge in developing a formal model for resource allocation is in defining a common unit of health benefit. Typically, the value of each specific intervention in health care is determined by considering a measure specific to the intervention or the disease process. Treatments for hypertension, for example, are evaluated in terms of blood pressure, while those for diabetes are evaluated by blood glucose. Yet, it is difficult to determine the relative value of investing in blood glucose rather than in blood pressure reduction. Traditional public health measures, such as life expectancy, are usually too crude to allow appropriate prioritization.[33]

I do not pretend to have either the wisdom or the authority to dictate what this range of medical options should be nor can any one special interest group prioritize these options. For his part, Kaplan suggests that a general health policy model (GHPM) "which separates aspects of health status into distinct components: life expectancy... functioning and symptoms... preference for observed functional states" would be a useful guide.[34] Useful, in that it measures health benefits and consequences of health along a “quality of well-being” scale[35] and can estimate the

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[33] Robert Kaplan, "A Quality of Life Approach to Health Resource Allocation", in Strosberg, M., Wiener, J, Baker, R. & Fein, A. (ed.). **Rationing America's Medical Care: The Oregon Plan and Beyond,** (The Brookings Institution: Washington D.C., 1992). p. 64.

[34] Kaplan, p.64.

[35] According to Kaplan, "quality-of-well-being"(QWB) is defined as a mathematical formula is:
QWB = 1 -(observed morbidity x morbidity weight)
- (observed physical activity x physical activity weight)
- (observed social activity x social activity weight)
- (observed symptom/problem x symptom/problem weight)

The net cost utility is defined as:

net cost = cost of treatment - cost of alternative effectiveness of many procedures and services provided by the health care system. This allows for the development of a rank ordering of services.[36]

Robert Veatch, in a realistic defense of the Oregon plan, comments that all the various decision methods regarding health care treatment comparisons have both positive and negative qualities, but in the end, "rationing is both inevitable and morally necessary."[37] The areas that should be of community and individual concern include the fairness of medical distribution, universality, claim rights to a minimal level of health care, constraints on experimental and unproven medical procedures and the prohibition of standardly accepted futile treatment. Regardless of the fact that no plan will be perfect, it is safe to say that it would be pragmatic folly to follow present day practices of simply waiting until a person's condition is such that it necessitates major medical intervention.

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net QWB x duration in years   QWB treatment - QWB alternative) x duration in years

"...A person of limited mobility, who requires a cane or walker to get around the community, might be hypothetically at 0.5 (on a community rated scale objective state functioning of 0.5-1.0). Over the course of an entire year, he or she would lose the equivalent of one year of life. A person who has the flu may also get 0.5 but the illness might last only three days. thus, the total loss in well-years might be 3/365 x 0.5 = 0.0004 well-years." (NB. In fact, this appears to be a miscalculation if the person is assessed at the half way mark; accordingly, the person would lose six months of life. Nevertheless, the comparison remains clear). pp. 66-67.
Kaplan continues:" Consumers must integrate various sources of information in their decision process. They are intuitively directed toward maximization of health outcomes. At times these decisions become overwhelming, however, and the use of a formal model may help them to make decisions." pp. 67-68.

[36] Kaplan, p. 64-72.

[37] Robert Veatch, "The Oregon Experiment: Needless and Real Worries", in Strosberg, M., Wiener, J, Baker, R. & Fein, A. (ed.). **Rationing America's Medical Care: The Oregon Plan and Beyond,** (The Brookings Institution: Washington D.C., 1992), p. 89.

One area that is ripe for the introduction of rational limits and restrictions upon what options are available to physicians and patients is new reproductive technology. This is not only because the costs of NRT can be high and the success rates low, but also because the individuals or couples who seek reproductive assistance possess very strong emotions on this topic and thus are more vulnerable and prone to try almost anything.

VI. *In Vitro* Fertilization

Some communities may wish to de-list In Vitro Fertilization (IVF) from basic coverage in all but a limited number of cases on the grounds that the costs of IVF are very expensive and the success rates are very low.[38],[39] Hence, contracts for this procedure should be considered the exception rather than the rule. Those who want IVF treatments may believe that their interests are being ignored and that they have a right to procreate and demand of others the assistance to do so when they cannot without medical intervention. However, the major causes of infertility are reported to be smoking, sexually transmitted diseases, poor nutrition and environmental and workplace hazards, all which are, in theory, preventable.[40] Accordingly, by re-focusing medical care on *both* prevention and health promotion activities[41], we can promote greater freedom of future potential patients.

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[38] Research by Goeree, R. et al. showed that: "Although the overall live birth rate was not significantly better…for the current mix of patients receiving IVF, this treatment was considerably more expensive than alternative treatments or no treatment…The researchers concluded, based on costs over six months' observations…IVF is not cost-effective when used to treat the wide varieties of diagnoses for which it is now used. "Cost-Effectiveness on an *In Vitro* Fertilization Program and the Costs of Associated Hospitalizations and Other Infertility Treatments." **in Research Volumes of the Royal Commission on New Reproductive Technologies**, **1993,** cited in, **Proceed with Care, Final Report of the Royal Commission on New Reproductive Technologies** Vol. 1., (Canada. Royal Commission on New Reproductive Technologies: 1993) p.519.

[39] One may want to argue that IVF or other new reproductive technologies should be de-listed because they are not treating 'medical disease'. However, if we adopt Arthur Caplan's definition of 'disease' whereby 'disease' refers to those dysfunctional states that a person recognizes or if left untouched will eventually come to be recognized as dysfunctional then infertility is a disease.

In issues such as the limitation of resources for reproductive technology such as In Vitro Fertilization (IVF), even though we are not "blaming" the individual by denying him/her treatment, it still may appear that way to the individual in question. The perception of blame, even when none is intended, is unfortunate. Preventative measures and education will assist future individuals, but it does not benefit those in the current situation. While we could try to engage in discussions of whether a) people do have a right to have children and b) if they do have this right, whether this right creates reciprocal duties for the community to assist them in exercising that right, this philosophical exercise would do little to appease those who are stricken with this disease.[42] Rather, IVF treatments should be severely limited as an area of possible contractual freedom for empirical reasons: "There is simply not enough evidence to determine whether IVF or its variants are effective or ineffective when diagnoses other than fallopian tube blockage are present, such as ovulatory defects, partial tubal blockage, tubal adhesions, seminal defects, or unexplained infertility."[43] Accordingly, it does not have to be a matter of "blaming" the individual or saying that they should have known better.[44] Instead, the reason why IVF is not normally an option open to contractual discussion is simply because it is an unproven treatment. The Royal Commission on New Reproductive Technologies adopted a similar stance when they recommended that:

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[40] These are the findings of the Canadian Royal Commission on New Reproductive Technologies. **Proceed with Care, Final Report of the Royal Commission on New Reproductive Technologies** Vol. 1., (Canada. Royal Commission on New Reproductive Technologies 1993), p. 340.

[41] See Sylvie Stachetchenko and Milos Jenicek, "Conceptual Differences between Prevention and Health Promotion: Research Implications for Community Health Programs," *Canadian Journal of Public Health*, 81 (Jan/Feb. 1990), p. 55.

[42] This exercise would also digress to complex discussions about systemic harm and the role of women in society. For example, would the permissibility of surrogate motherhood promote the view that the reproductive role of women can be commodified by social pressures?

> Having children is important to most Canadians, and if effective, safe techniques exist to achieve that goal, it is appropriate that they're offered as part of the health care system in a non-discriminatory way, for example, prenatal diagnosis for serious disorders, IVF for blocked fallopian tubes, and donor insemination if there is no fertile male partner. However, it is unethical to offer as services unproven procedures or treatments, and it is irresponsible to devote public resources to them. Procedures without good evidence of effectiveness should be considered research and regulated as such. Health care resources are limited and the continued provision of unproven, ineffective, expensive technical procedures undermines the system by using resources without evidence of benefit. In fact, an evidence-based approach taken throughout the health care system would allow society to better use existing health care resources and manage the system better.[45]

Indeed, the medical and financial resources that would be spent on unproven IVF treatments could be more efficiently shifted over towards eliminating the need for the procedure. Accordingly, although some of the current potential candidates will be denied access, such a denial can be grounded in empirical justification. Again, if we were to provide them with access, there is no reason to believe that success would be achieved. In addition, such prohibitions or warnings against some of these new technologies puts boundaries around the provider-patient contract and, hence, concerns regarding unacceptable contractual individualism can be minimized.

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[43] Royal Commission on New Reproductive Technologies, **Proceed with Care, Final Report of the Royal Commission on New Reproductive Technologies**, Vol. 1(Canada. Royal Commission on New Reproductive Technologies: 1993), p. 520.

[44] As well, it might be considered dishonest to claim that people should 'know better' because part of the blame must rest on the social institutions that fail to provide the individuals in question with reasonable information or education regarding the risks, options and solutions.

[45] Royal Commission on New Reproductive Technologies, **Proceed with Care, Final Report of the Royal Commission on New Reproductive Technologies**, Summary (Canada. Royal Commission on New Reproductive Technologies: 1993), p. 7.

VII. Consequences

So what does all this suggest? First and foremost, our previous discussion surrounding the difficulties of surrogate decision making draws our attention to the uncertainty as to how to determine the best interests of patients as persons.[46] This, in turn, makes it difficult to determine if the contract that the patient has entered into is fair or unfair. We cannot look to the attending physician's personal values since they may be unrelated and different from those of the patient. We cannot rely upon a professional-centered ethic to provide us with assistance due to its unjustified medical paternalist overtones. We cannot use surrogate decision-maker's values simply because he/she is not the individual who will be directly affected by the decision and his/her values may be different from those of the patient's. We cannot use substituted judgments due to their resting upon an inappropriate hypothetical state of affairs that fails to reflect the true nature of the patient's situation. We cannot trust the appropriateness of current advance directives or living wills to accurately reflect the patient's true interests nor can we count on the surrogate representatives to decide according to what the patient wanted. Finally, if patients are incompetent or not informed, we cannot even rely on them to give us accurate and morally binding directions.

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[46] See Chapter Seven previous.

We know that patients need to be better informed and given greater control over self-directed decisions. We know that physicians must bring with them a body of knowledge and professional integrity to ensure that the patient is not harmed. What we also know is that a fair amount of medical funding is spent trying to respond to immediate crises, threatening harms and the last stages of life. By re-focusing medicine, both in terms of process and resource allocation, we will go a long way in reducing the numbers of people who may find themselves in situations where they (rightly or wrongly) desire a treatment which the community must respond to by saying "We are sorry but that treatment is unreasonable".[47] In concrete terms, this can be done by redirecting some (but not all) attention upon health promotion. Health promotion is aimed at the general population and is considered to be a 'participatory model of health'. This model may be followed by means of developing our community health care system to include greater emphasis on clinics, pre-natal care, home care and preventative care education rather than simply waiting to respond to a patient's medical needs.

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[47] Reports from the Library of Parliament suggest that according to health services researchers, up to 40% of patient hospitalization and medical procedures are unnecessary or inappropriate. *Health Policy in Canada*. Nancy Miller Chenier, Political and Social Affairs Division, October 20, 1993.

Would there still be room for contracts? Yes, although the community places a much more direct role in establishing acceptable guidelines than before, it should not be viewed as smothering the contractual process. One must not forget that the traditional *laissez-faire* approach has various rules (i.e., disclosure, intent etc.) that can also affect the contractual freedoms of parties. The liberal-communitarian approach puts in place contractual safety nets and guidelines that can vary significantly depending on what the community has set out, but which are directly based upon principles of autonomy and beneficence. Parties still have the latitude to engage in contracts that are just more regulated to promote fairness, trust and cooperation. In turn, these elements will benefit all those involved.

Michael Decter suggests some common-sense approaches to getting people involved and more knowledgeable about health care, which will therefore reduce the threat for a community tyranny over the individual.[48] According to Decter, there should be more patient and public education and, as well, medical costs should be transparent to everyone. Furthermore, individuals should be more involved in the health care system either as volunteers, consumer representatives on boards or as part of health care lobbies or associations.[49] We should also add to this growing list the notion of an "informed potential patient". By becoming more knowledgeable, the informed patient will have greater opportunities to smooth out the inequities between the position of the provider and the patient. This, as noted earlier, can be done with the use of interactive video disks, but also more basic education that is in keeping with the preamble of the Canada Health Act which states, "Canadians can achieve further improvements in their well-being through combining individual lifestyles that emphasize fitness, prevention of disease and health promotion with collective action against the social, environmental and occupational causes of disease".[50] Following these actions, the informed potential patient will be in a better position when entering a relationship with his/her health care provider since his/her knowledge, expectations and hopefully well-being, will place him/her in a less vulnerable position.

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[48] Decter, Michael, **Healing Medicare: Managing Health System Change the Canadian Way**, (Toronto: McGilligan Books, 1994).

[49] See Decter's discussion on this matter in chap. 9 of **Healing Medicare**.

VIII. Caring Providers

To promote the fairness and trust of the medical contract, we should be capitalizing upon the variety of experts and areas of expertise that non-physicians could provide us within the atmosphere of cooperation and teamwork. Such steps have been already taken in the Scandinavian countries of Finland and Denmark and, thus, provide empirical support for some of the theoretical claims argued in this work. Finland, (which is the

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[50] *Canada Health Act, 1984*. C.6 Preamble.

World Health Organization model country because of its progressive health care system), not only places public health programs at the center of their health care delivery, but also promotes the integration of various health care services.[51]

> The philosophy of the health centres (in Finland) is to provide services that are based on an interdisciplinary team approach. Interdisciplinary team members include physiotherapists, social workers, public health nurses, environmental health inspectors, veterinarians, pharmacy assistants, lab and x-ray nurses, primary nurses and nurses' aids, dentists, physicians and inpatient nurses. There are also support personnel including receptionists, laboratory aids, dental assistants, office workers, service and housekeeping workers, bathing personnel and a telephone operator.[52]

By increasing the responsibilities of nurses to include such things as making simple diagnoses and performing routine check ups, we are moving away from the traditional dependent role of "physician's servant/attendant"[53] towards the role of a practitioner-nurse or nurse-specialist. It will be natural then, to want to include them under the umbrella of the "provider-patient" relationship.[54],[55] This seems to fit only with a unified theory as the nurse tends to be the professional who works most closely with both the patient and physician.

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[51] Susan Duncan, *A Study of Primary Health Care in Finland and Denmark: Analysis and Implications for Canadian Health Reforms*, Submitted to the Pan-American Health Organization, October 1996.

[52] Susan Duncan, p. 19.

[53] Even though it is not the case that all nurses are female, the classic nursing literature uses the expression 'Physician's Handmaiden' to capture the historical gender-specific nature of the role.

[54] There are numerous articles and collections on this issue including: Ora Stickland & Dorothy Fishman (ed.), **Nursing Issues in the 1990's** Delmar Publishers (1994); Geoffrey Hunt & Paul Wainwright, **Expanding the Role of the Nurse, Blackwell Science**, Oxford (1994).

[55] Some of the activities that Hunt and Wainwright list as being in keeping with the expansion of nursing as an autonomous profession include: Assessment of patients' or clients' physical and psycho-social needs; Expertise in making clinical judgments, nursing diagnoses, prognoses and treatment decisions; Teaching and educating patients or clients and their friends and relatives; Developing strategies, linkages between nursing theory and practice; Consultation and nursing leadership; Patient advocacy; Managing and coordinating patient services. Hunt and Wainwright, p. 106.

The traditional laissez-*faire* theory of contract as applied to medicine does not have the means to resolve the difficulty of multiple contracts which the patient may have formed with his/her health care providers (and which the providers may have formed with other parties such as the hospital institution). This is especially the case if the nurse assumes a patient-advocacy approach. The authority of the nurse as an advocate for the patient as well as being a significant and autonomous player in the health care system can be seen within Henderson's classic definition of nursing:

> The *unique function of the nurse is to assist the individual*, sick or well, in the performance of those activities contributing to health or its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible. This aspect of her work, this part of her function, she initiates and controls; *of this she is master.*[56] (Emphasis mine)

The patient may, for example, believe that his/her physician is withholding information from him/her and may request, against hospital policy, that the nurse disclose information about his/her medical status. If each health care professional has an independent direct contract with the patient and they, in turn, have contracts with the institution *and* there is no mechanism for coordinating these contracts, then the stage is set for greater conflict and conflicting loyalties.

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[56] Henderson, V., **Basic Principles of Nursing Care**, cited in Henderson, V., **The Nature of Nursing: Reflections after 25 Years** (National League for Nursing Press: New York, 1991), p. 22.

Recent nursing literature presents us with one interpretation that may ultimately help us resolve this potential concern within the confines of the liberal communitarian contract theory. Jecker and Self argue that "traditional thinking" is that the role of the physician is to "cure" the patient whereas the role of the nurse is to "care" for and about the patient.[57] As such, these two contrasting roles can lead to dilemmas such as the one stated in the previous paragraph. However, if we combine both the "care" and "cure" models (as Jecker and Self do) so that both the nurse and the physician care for the patient, but strive to achieve this end in different ways, then we can interpret the role of the provider (who is either a physician or a nurse in this reading) as being part of comprehensive team effort that is made on behalf of the patient. Furthermore, this encourages movement away from minimalist approach to the provider-patient relationship. By moving in this direction, the ideals of the liberal communitarian model, which include the promotion of fairness, trust and cooperation, are maintained since all the parties involved are working from the same principles and with the same purpose. Adherence to these ideals, (or rather the lack thereof) is clearly the cause of a patient's concern when he/she requests the nurse to be forthcoming with information when the physician is not. Furthermore, a provider team approach that emphasizes the caring element of "health care" learns more about the patient as a person and creates an environment where the contract need not be minimalist in nature. Thus, if cure is impossible and treatment or intervention is inappropriate, a patient should still be able to expect to be cared for.

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[57] Jecker, N., Self, D. "Separating Care and Cure: An Analysis of Historical and Contemporary Images of Nursing and Medicine", *Journal of Medicine and Philosophy* 16 (1991) pp. 285-306.

Rethinking health policy as a development of a contract in which the delivery of medical services is motivated by the promotion of well-being as opposed to the treatment of illness may provide more members of the community with satisfactory health care that is also fiscally responsible. The reason for this is the recognition of the reciprocal ties between the promotion of the common wealth and the promotion of the welfare of each member of the community. Accordingly, by bringing together the various players and measures discussed in the previous pages, we will reduce the fear that the community will serve only to create debilitating restrictions upon the individual liberty rights of the contracting parties in order to prevent individualist approaches.

IX. A Community of Patients and Providers

Rethinking our policies in terms of community decision-making can allow for further extensions of autonomy. The guidelines and constraints put in place by the community may be no more intrusive in nature than those already in place under traditional contract theories. However, the guidelines go further to balance competing interests and bargaining positions. Furthermore, (and perhaps more significantly) by the same sort of reasoning that sees direct democracy as containing the liberal ideal of allowing each citizen to have a say in health care decisions that affect him/her (directly or indirectly), the placing of decisions in the hands of the community allows those who will be affected to give their consent to be governed in the medical sphere. Community committees that are made up of a representative slice of the population, including health care providers, lay persons, social, political and legal figures, psychologists, sociologists, human resource personnel, persons with disabilities, the ill and the healthy, can provide the means by which individuals can better realize common interests rather than relying solely upon the good will and medical expertise of the physician and/or their own limited knowledge. Such committees, public hearings and meetings must adequately represent all members of the community and a reasonable amount of discussion and investigation must occur in order for there to be fairness. One of the failings of the Oregon Health Plan was the limited number of individuals and special interests groups who actually got involved in the ranking process. Norman Daniels noted that the Oregon community meetings were too brief and the discussion "too superficial to develop a clear picture of community values."[58] Further, he charged that the community meeting process was usurped by its non-representation of those affected the most by the rationing (i.e., the poor) and that this situation is unfortunate. "By having the opportunity to participate in community deliberations regarding policies affecting their lives, people can realize a deeper aspect of autonomy, namely, participation in deliberative dialogue."[59]

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[58] Norman Daniels, *Justice and Health Care Rationing: Lessons from Oregon*, in Strosberg, M., *et al* (ed.) **Rationing America's Medical Care: The Oregon Plan and Beyond** (The Brookings Institute: Washington D.C., 1992) pp. 190-191.

[59] Linda L. Emanuel and Ezekiel J. Emanuel, "Decisions at the end of life: Guided by Communities of Patients" *Hastings Center Report* 23, no. 5 (1993); p. 11.

Would, a community-minded approach better realize our common interests in beneficence and autonomy? Probably, since limiting the freedom of patients to contract with their physicians can actually benefit all concerned. If a set of standard medical practice guidelines are developed (in a just manner) by the community and these guidelines lay out which medical options are open or closed to all contracting parties, then much of the uncertainty and the accompanying stresses that face patients and physicians will be alleviated. Patients will know what their future will hold, for instance, by knowing that they will not be undignified by being kept artificially alive. Such knowledge strengthens the patient's own position within the physician-patient relationship and assists in developing trust between the parties. Policies reflecting medical realities as well as permitting a limited amount of autonomy for the patient (e.g., not permitting the application of futile treatment) will be in place for the evaluation of what constitutes reasonable care for the competent and incompetent. Physicians, thus, can feel more secure in the realization that they are fulfilling their contractual responsibilities. They will also have the pressure of dealing with irrational or unreasonable patients' demands noticeably reduced. The community then becomes a partner in the provider-patient contract thereby removing any concern regarding individualism and minimalism. Notice that in this scheme of things, we have not introduced new levels of complexity but rather the same principles are being applied across the board. The specific actions that follow from these principles will be consistent, although they may be different, as the composition of the contracts and communities will vary from case to case.

Would a community standard that sets guidelines for health care for both the competent and the incompetent patient value patient autonomy? There is some evidence to suggest that the answer is "Yes". We have reason to believe that in many cases the community standard would be equal to, if not superior to, the accuracy of advance directives, living wills and surrogate decision-makers in certain situations. In assessing whether the directives of the community would match the subjective interests of individual patients, the Emanuels discovered that the standards of a community of health care patients regarding specific clinical situations and life sustaining treatment decisions with PVS individuals[60] had a 80% success rate in terms of their ability to match a patient's preferences as compared to 79% for living wills, and 67% for proxy designation.[61] They concluded: "Thus, from the empirical data that are available, it is reasonable to think that community standards are probably very similar to instructional directives and proxy decision making in their ability to match patient's preferences."[62] Furthermore, even though we are restricting the ability of patients to request futile treatment, this limitation does not infringe upon their autonomy in any meaningful way since the treatment or non-treatment will have the same net effect.

There are justifiable limits and conditions that the community can place on the patient's autonomy, including, for example, ensuring that the patient is competent to make a decision, that the patient is informed and that the options available to the patient are effective and relatively safe.

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[60] The particular cases involved Permanent Vegetative State patients and the use of mechanical ventilation.

[61] Emanuel & Emanuel, p. 11.

[62] Emanuel & Emanuel, p. 11.

Would the community guidelines ration health care? Yes. Rationing or prioritizing health care has negative connotations for we ration food in times of hunger and we ration water in times of drought. Yet, we are only now beginning to recognize that health care, medical treatments and the funds required for them are also in limited supply. Accordingly, the conservation of medical care, just like the conservation of food and water or even the conservation of the environment, will require our attention. Veatch writes: "In a world of finite resources, it is irrational for a society to support a health plan that would do what is literally medically best for patients, when cutting slightly below that point would release resources to be used in ways that were much more efficient or equitable." [63]

Hence, instead of reacting only after the seriousness of the situation has been realized (much like the current practice of waiting until after the person gets seriously ill before medical intervention is suggested), we should look to "preventative health care distribution" where the prevention is not just about avoiding illness and disease, but is about the long term allocation of dollars and sense.[64] We can no longer ignore the possibility of limiting a person's access to whatever medical treatment he/she wants. However, just because a person is denied a particular treatment, this does not mean that his/her interests are being sacrificed for the good of the community. If the requested treatment were considered futile, then the patient would not benefit from the treatment. Accordingly, if the patient is denied futile treatment, he/she is not being harmed and his/her interests are not being sacrificed. As well, since the patient interests are not negatively affected by the lack of futile treatment and since the community's interests are being positively affected, such rationing makes good sense. However, we must be clear in stating that limiting futile treatment and unproven procedures like IVF in conditions other than full fallopian tube blockage is not being instituted on the grounds of rationing health care services. Such treatments would still be restricted even if they were inexpensive because they provide no benefit or (as in the case with IVF) they have not been shown to provide benefit.

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[63] Robert Veatch, "The Oregon Experiment: Needless and Real Worries", in Strosberg, M., *et al* (ed.) **Rationing America's Medical Care: The Oregon Plan and Beyond** (The Brookings Institute: Washington D.C., 1992) p. 79.

[64] The pun is intentional.

X. A Final Survey: Where are we now? Where do we need to be?

We note, with approval, that the first steps towards offering medical treatments within the parameters of community sensibilities have been taken by many groups and governments within Canada.[65] The Maritimes are considering an amalgamation of their regions into a single community with the aim of coordinating medical services.[66] New Brunswick's Commission on Selected Health Care Programs (1989) recommended, among other things, consistent regional planning and the development of outpatient clinics and extra mural hospitals. Nova Scotia's Royal Commission on Health Care recommended the setting up of a provincial advisory council. Ontario has looked to the enhancement of community-based care and strengthening the team of health care providers and established Comprehensive Health Organizations. The Province of Saskatchewan has organized its communities into "health districts" while Quebec has its *Centres locaux de services communautaires* and has investigated everything from the role of nurses and improving community consultation to the replacement of health service councils with regional boards. Manitoba's Minister of Health envisioned a "partnership which engages all parts of the health services system including the individuals whose health is at stake."[67] British Columbia has created the College of Nurses and the Victoria Health Project that redesigned clinical programs and provided alternatives to hospitalization (including wellness centers and support programs for family caregivers). British Columbia is also in the process of developing regionalized medical committees to oversee the distribution of medical services. These groups also point to the fact that communities need not be the same monolithic entity as the "State".

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[65] Unfortunately, with the tendency of national interests to be focused on reducing costs and given that governments change hands over time, some of these initiatives have been re-evaluated.

[66] The following information was taken from: Crichton, A., Hsu, D., & Tsang, S., **Canada's Health Care System: Its Funding and Organization**, (Canadian Hospital Association: Ottawa, Ontario, 1994) Ch. 22.

The liberal communitarian model assumes that society is more than just an economic bond but rather that society is made up of numerous communities each of which is a collective. Working within the collective and in accordance to the generally accepted norms, the health care provider - patient relationship may be seen as balancing the burdens and benefits of all concerned and of balancing individual liberty with appropriate paternalist interventions and policies.

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[67] Anne Crichton, p. 286.

As we are all potential patients, we can only hope to see stronger provider-patient ties being promoted by reorganization measures that give more power to those who are affected by the decisions and treatments of the medical profession. Through the creation of accountable organized groups and gatherings including: national and local supervisory boards; broadly constituted health policy committees; town hall meetings; and even informal one-on-one discussions between the provider and the patient, we hope to foster greater respect for not only the autonomy of competent patients to choose responsibly and with guidance, but for the promotion of the objective and subjective interests of incompetent patients as well.

We must also respect the autonomy and integrity of the physician and other health care providers. While patients' rights movements are significant, at the extreme, patients cannot be given full control of their own medical treatment without having parameters set or guidance provided concerning complex medical matters. When we are trying to restore proper balance between the parties involved, the health care provider should not be reduced to that of servant or tool. Likewise, the patient should not be forced to continue to play the role of the passive bystander as they have done under the Hippocratic Oath tradition. If a patient is denied the right to choose by others or if he/she lacks relevant knowledge, is not informed or is incapable of exercising autonomy, then he/she is not free and if he/she is not free then he/she is unable to enter a valid contractual relationship.

Under the proposed contract theory of medical ethics, the community has a part to play in the decision making process regarding what is permissible or required by those directly involved in the medical situation. Stemming from communitarian ideals, a notion of limited or guarded beneficence is endorsed with qualification as it relates to the incompetent. Such a restriction is not new to contracts and so those who are cautious proponents of a contract interpretation should not consider them too great an intrusion. The values of the community, if properly determined, ought to direct, in a broadly defined sense, what physicians and patients can do. Hence, this particular theory may be less successful in an American health care system as it presently stands. The reason for this is, as we've seen, because the American system is much more geared towards the individualistic model of capitalist consumption which we have rejected. Nevertheless, there is a glimmer of community spirited legislation in some American states such as in Oregon where community guidelines and standards are being implemented and revisited. Even libertarians will acknowledge that within a *laissez-faire* system it is permissible for communities (as opposed to the State) to impose standards, restrictions and paternalistic interventions on their members. Libertarian Robert Nozick writes:

> The operation of the (utopian) framework has many of the virtues, and few of the defects people find in the libertarian vision. For though there is great liberty to choose among communities, many particular communities internally may have many restrictions unjustifiable on libertarian grounds: that is, restrictions which

> libertarians would condemn if they were enforced by a central state apparatus. For example, paternalistic intervention into people's lives, restrictions on the range of books which may circulate in the community, limitations on the kinds of sexual behavior, and so on. But this is merely another way of pointing out that in a free society people may contract into various restrictions, which the government may not legitimately impose upon them. Though the framework is libertarian and laissez-faire, *individual communities within it need not be* (Nozick's emphasis), and perhaps no community within it will choose to be so.[68]

Regardless of its appeal to our neighbors to the south, the liberal communitarian contract model which we have applied to medical ethics has the distinction of capturing some of the important social and political values that highlight the commitment of Canadians to view health care as a right and not as a privilege. It also recognizes the importance of liberty and responsibility for all those involved. By providing the opportunity for a greater role for patients by means of enhancing their bargaining position and by the chance to get involved (either as a patient or as a community member), we remove the remaining concerns of anti-contractarians who have pointed to the ineffectiveness or inappropriateness of prescribing contract theory to the provider-patient relationship.

By recognizing the rights and responsibilities and limitations of all parties involved in the contract and by providing the opportunity for parties to consent to the content of the contract, we can assert elements of fairness, cooperation and trust. As members of a community, some of us will play the role of health care provider while others will play the role of patient.

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[68] Nozick, R. **Anarchy, State and Utopia**, (New York: Basic Books, 1974) p. 330

Both of these roles are difficult and complex and it is crucial that we aim to promote the continued respect that providers and patients deserve.

Some time has passed. It is dawn. And as Deeker peers out across the lake, he can make out the opening of the channel ahead. A light mist disguises some of the turns and obstacles and yet the shape of islands, trees and buoys are coming alive with detail. It is as if with the cool dawn breezes, the lake is awakening not only the captain, but itself...

Jeff McLaughlin, "Frayed" (1988)

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